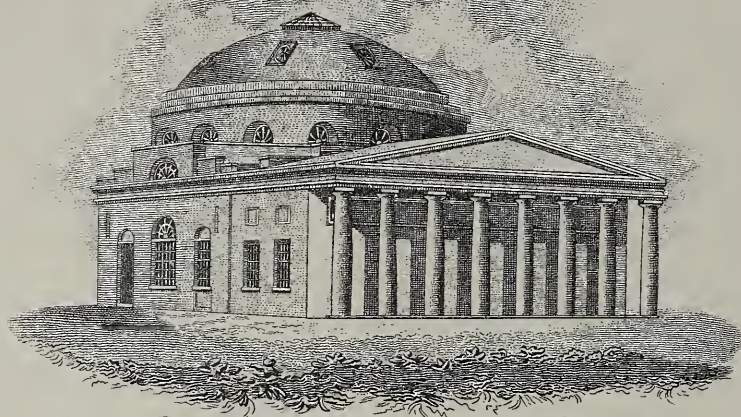


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The Physician's Bookshelf

400 Years of a Doctor's Life, an anthology collected and arranged by George Rosen, M.D., and Beate Caspari-Rosen, M.D., (\$5.00. *Henry Schuman, Inc., New York City*). The description of the early years in the life of physicians is taken from the writing of some 11 of them (1785 to 1865); school days from eight (1762 to 1875); student days from 32 (1501 to 1891); days of practice from 28 physicians (1493 to 1883). Efforts as a scientist, scholar, teacher are told by 23 physicians in the writings (1501 to 1891). The life of a physician as a married man is taken from the writings of 19 of them (1536-1878). How doctors behave as patients has been recorded by some 12 physicians (1665 to 1870). The military experiences of a doctor through the ages are told by 15 of them (1510 to 1897). Doctors' writings and politics are from six of them (1745 to 1813); and finally the reflections of nine of them on life and death (1758-1878). So the authors have brought together the material from which we can construct the picture of the physician. Out of the many ventures in autobiography made by doctors in the last four centuries, there have been chosen passages which are most revealing of the medically trained human being in the world. A delightful volume for your library.

Diagnosis in Daily Practice, by Benjamin White, M.D., and C. F. Geschickter, M.D., (\$15.00. *J. B. Lippincott Company, Philadelphia*) is an excellent office volume based upon the incidence of various diseases. Some of the best diagnosticians have been "book-makers" on symptoms. It is a large manual of some 700 pages, well illustrated and filled with helpful outlines, tables, and charts. It is intended for the practitioner's office where it can serve as a guide in the selection and employment of a daily outline which will embrace the more important and comprehensive diagnostic procedures.

Tropical Nutrition and Dietetics, Second Edition, by Lucius Nicholls, M.D., (\$7.50. *Bailliere, Tindall, and Cox, London, England*) a sane discussion of the factors and foods involved, all in the hope that the knowledge and means for better nutrition should lead to an improvement in the quality of the individuals of the masses rather than to an increase in their number.

The New Way To Eat and Get Slim, by Donald G. Cooley, (\$2.00. *Wilfred Funk, Inc., New York City*) is the eleventh printing in five years. The plan emphasizes the necessity of cracking down on calories while keeping up the protein requirements which is the real key to this plan.

Diseases of Children, Including Dietetics and the Common Fevers, by Bruce Williamson, M. D., (\$4.50. Fifth Edition. *William & Wilkins, Baltimore, Maryland*) gives us a pocket-sized British manual brought up to date with a discussion of penicillin and other recent discoveries.

The Ego and the Mechanisms of Defense, by Ann Freud, (\$4.00. *International Universities Press, Inc., New York City*) discusses the theory of the mechanisms, the preliminary stage of defense, by the avoidance of objectives "pain" and defense motivated by fear of the strength of the instincts.

Surgical Pathology, by William Boyd, M. D., (\$10.00. Sixth Edition. *W. B. Saunders Company, Philadelphia*) comes five years after the fifth edition. In the meantime, another world's war has been fought and a considerable number of new things have been revealed.

Sex in Our Changing World, by John McPartland, (\$2.75. *Rinehart and Company, New York City*) is a sensible book that faces squarely the misunderstandings of the rules of the game. It attempts to correlate our behavior with the times and asks if this is the best way.

Red Miracle, by Edward Podolsky, M. D., (\$3.50. *Beechhurst Press, New York City*) is the story of Soviet Medicine. It will have to be read to be appraised.

From Denmark to the Virgin Islands, by Knud Knud-Hansen, (\$2.00. *Dorrance & Company, Philadelphia*) is a biography of a medical man on a small tropical island. All who like medical biographies, travel, or anthropology, will enjoy it.

Promise of Love, by Mary Renault, (\$2.50. *Wm. Morrow and Company, New York City*) is a first novel about a first love and interests us because the heroine takes up nursing and a part of the discipline this love has is her association with a surgeon who is the hero's superior in the laboratory. The story is well done and gives a swift dramatic picture of life in an English hospital. It is sincere and not sensational or melodramatic which would have been the easier way to handle the plot selected.

Surgical Disorders of the Chest, by J. K. Donaldson, M.D., (\$8.50. Second Edition. *Lea & Febiger, Philadelphia*) is a revised text on the subject which stresses the practical and therefore can serve equally well as a reference.

Science Advances, by J. B. S. Haldane, (\$3.00. *Macmillan Company, New York City*) presents a series of essays telling the story of the growth

of pure and applied science. A delightful book by this old British scientist.

Synopsis of Allergy, by Harry Alexander, M.D., (\$3.50. Second Edition. *C. V. Mosby Company, St. Louis, Missouri*) presents allergy as a full-grown branch of medicine. In this second edition, the additions have to do with classification of ideas and simplification of procedures. Even the conservative editor of *The Journal of Allergy* now recognizes that some of the cases of so-called non-atopic, or "intrinsic allergy" may be associated with infection and are possibly cases of bacterial hypersensitiveness. With this goes a report on the newer work on vacular allergy and significant advances in the field of allergy to drugs (chemicals). Throughout the book, however, there is clear recognition of the fact that future advances must come from the more basic fields of immunological physiology. It is an excellent and handy manual reasonably priced. All that a man in other fields of practice, or a medical student, needs.

The Practical Nurse, by Dorothy Deming, R.N., (\$3.00. *The Commonwealth Fund, New York City*) reviews and evaluates the factors involved financially in recruiting nurses for hospital and home duty, with special reference to the acceptance and use of the practical nurses. It recognizes the all-time high in professional nursing shortages. After reviewing the need for services such as the practical nurse can give, it reports on how and where practical nurses are being used. The conclusion reached is that they are here to stay and should be used to advantage in all situations where they can be used. Nothing is said of the overly long training of the graduate nurse or her attempt to become a doctor due to a disintegrated medical curriculum and the resultant shortage of physicians.

An Atlas of Anatomy, by J. C. B. Grant, (\$10.00. *Williams and Wilkins Company, Baltimore, Maryland*) is an attractive volume of 591 beautiful illustrations of extreme accuracy depicting the structures of the human body, region by region, in much the same order as the student displays them in his dissection.

Communal Sick-Care in the German Ghetto, by Jacob R. Marcus, Ph.D., (\$4.00. *Hebrew Union College Press, Cincinnati, Ohio*, 1947) is a description in some detail of the late medieval period. The concern here is only with the action of the Jewish community and its accredited agencies in providing medical services.

May's Manual of Diseases of the Eye, edited by Charles A. Perera, M.D., (\$4.00. Nineteenth Edition. *Williams and Wilkins Company, Baltimore, Maryland*), is still the outstanding text for medical students as its reception for the last 47 years will testify.

The Causation of Appendicitis, by A. Rendle Short, M.D., (\$2.50. A William Wood Book. *Williams & Wilkins, Baltimore, Maryland*) has been written by an observer who believes there has been a great increase in this disease between 1895 and 1905; that in uncivilized countries there is very little appendicitis except among those natives who take to European food habits; and suggests that the cause of the increase was the relatively smaller quantity of cellulose eaten on account of the wider use of impure foods.

It is refreshing to come across a book concerned with the ultimate cause of a disease. For 75 years, we physicians have neglected this field. The author centers his attention on the liquid contents of the blood and does make a good case for his theories but he has overlooked the fact that appendicitis is a spastic organ and therefore is subject to changes in the weather. Undoubtedly both the lack of cellulose and the change in the weather account for the occurrence of this disease.

Mineral Year Book, 1945, H. D. Keiser, Editor, U. S. Department of the Interior, (\$4.00. *U. S. Government Printing Office, Washington, D. C.*) has just come out. It is a summary of what the mineral industries did to win the last war and gives you some idea of what is left with which to carry on. Every citizen should read it carefully before he howls for world trade or proposes to slap the Big Bear in the face.

The Genesis of Dental Education, by Van E. Dalton, D.D.S., (*The Author, Circleville, Ohio*) is an outstanding monograph. It treats of four major subjects: I. The Glory of Bainbridge, Ohio, as the Cradle of Dental Education; II. The First Dental Societies; III. The Beginning of Dental Legislation in the United States; IV. The History of the Ohio College of Dental Surgery. Every Ohio physician should read this little volume that he might take the proper pride in this great state of ours. We all should know intimately the life of Daniel Drake, of Delameter, of J. Potter Kirkland, of Starling Loving, and of John Harris. This book will help.

Pictorial Handbook of Fracture Treatment, by Edward Compere, Sam W. Banks, and Clinton Compere, (\$5.50. Second Edition. *The Year Book Publishers, Chicago*) has been extensively revised. This book is a fine example of how illustrations can best be used for teaching.

Pharmacology, Therapeutics and Prescription Writing, by Walter A. Bastedo, M.D., (\$8.50. Fifth Edition. *W. B. Saunders Company, Philadelphia*) has been completely rewritten to cover the many new remedies and to give in detail the modern treatment of shock, anemias, malaria, and syphilis.

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The Diabetic Patient

HENRY J. JOHN, M.D.

THE diabetic patient today is incomparably more fortunate that he was twenty-five years ago, and should have no complaints about the relatively easy routine to which he is subjected. Before the insulin era, the diabetic was pitifully restricted and starved in an effort to postpone the ever-menacing death from the disease. Now, as time has proved, a diabetic can do everything that a non-diabetic can do. He can take a liberal diet, provided his insulin dosage is properly adjusted to enable him to utilize that diet, with close and adequate medical supervision to assure avoidance of difficulty.

When they are under proper control, diabetics can have major operations with practically the same safety as non-diabetics. They can go through infections provided they have an adequately increased dose of insulin during that period. They can recover from diabetic coma, a condition which, before the insulin era, was

The Author

● Dr. John, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, Cleveland, 1916; fellow, American College of Physicians; member, American Diabetes Association; and visiting physician, University, St. Luke's, and Huron Road Hospitals.

fatal. They can be carried through childbirth with reasonable safety. Diabetic children can look forward to normal development and accomplishment, and can plan their future lives. In the pre-insulin era, they had only death to look forward to.

We have had insulin now for twenty-five years. Table 1 shows clearly the great progress that has been made during this time. Hence the diabetic today has much to be thankful for, and he should be made to realize it. No diabetic patient should be allowed to feel sorry for himself and lead a miserable life for this reason. The physician should remind him of the difference between the pre-insulin era and now, and should instil in his mind the idea that the simple routine he has to follow is little more onerous than having to shave, to wash one's face, or to take a bath each day. This proper psychologic emphasis often spells the difference between successful and unsuccessful handling of a diabetic. It is always a mistake to treat the diabetes, and to forget the individual who has diabetes. The principal medical problem is to make the routine as

Table 1.
Progress in Treatment of Diabetes During
the Insulin Era

	Before Insulin	Insulin Era	Decrease
Surgical mortality (4 authors).....	40.63%	16 %	57.8%
Surgical mortality (22-40 authors).....	24.2%	5 %	80.0%
Mortality from diabetic coma (424 patients).....	100.0%	19.2%	80.0%
Mortality in diabetic children.....	99.0%	3.0%	96.0%
Mortality in tuberculous diabetics.....	100.0%	81.1% (Joslin)	
Longevity.....		Markedly prolonged	

Presented at the Annual Meeting of the Ohio State Medical Association at Cleveland, Ohio, May 6-8, 1947.

easy as possible for the patient—whether he is a child or an adult—and at the same time adequate for his protection.

Although the progress made in the treatment of diabetic patients has been enormous during the last twenty-five years, there is still much to be learned about diabetes, and future decades will, no doubt, bring forth further surprises. There are still some problems which disturb us greatly, which we do not yet understand. Arteriosclerosis is a frightening sign, especially among younger diabetics; this often affects the retina, with retinal hemorrhages and cataracts, or is manifested as intercapillary nephrosclerosis. Arteriosclerotic gangrene in diabetic extremities also is still a grave problem. Much research remains to be done to clarify the etiology of these complications, so that they may be prevented.

PROTECTIVE AND PREVENTIVE MEASURES

Moderation in eating is a great aid in preventing diabetes, and conversely, overeating and its attendant obesity constitute prime factors in causation of the disease. Clinical findings reveal that an exceedingly high percentage of diabetic patients are overweight, not only at the time they are first seen, but especially before that, when there were no symptoms of diabetes. Often moderation in eating, causing weight reduction, leads to a remarkable improvement in insulinogenic function. In this connection, it is interesting to note the effect of war on diabetes. Statistics in both world wars show that the incidence and mortality from diabetes dropped conspicuously during the war years and for a year or two afterward, with a subsequent rise. This simply means that the scarcity of food during the war automatically led to a restricted diet for the population generally, which protected many so-called prediabetics sufficiently that they did not develop the disease.

When the incidence of diabetes is high in a family, it is wise to check the children and find out which members of the group have a predisposition to the disease, so that they can be protected. There is no need for those whose insulinogenic function is normal to be subjected to specially restricted diets. Much can be done in this way to prevent, or at least postpone, the onset of diabetes in susceptible individuals for at least a decade or more.

Is there any cure for diabetes? This is a question which is asked repeatedly by patients. The answer is an emphatic no. "Once a diabetic, always a diabetic," still is true, even though there are some cases in which improvement of the diabetic condition is so pronounced that it practically resembles a cure. Without the knowledge gained by experience, one could easily

be misled into thinking that such a patient is cured. However, if the patient is followed closely over a period of years, and if repeated checks of blood and urine are made, there will eventually be some evidence of deterioration, and insulin will have to be administered to correct the recurring hyperglycemia. Once good control is reestablished, however, the patient may again return to an apparently normal status, and remain there for months, sometimes even years. This is termed "recession" of the diabetes. It is not a cure.

Recurrence of diabetes in such individuals depends on several factors: (1) Excessive intake of food and/or drink, which leads to increase in weight; (2) any infection, especially one which causes prolonged fever, and sometimes even a mild infection of short duration, such as tonsillitis or a common cold; (3) pregnancy; (4) acidosis or coma; and (5) gangrene, especially moist gangrene, which causes havoc even in the mildest diabetic or prediabetic. In the presence of any of these factors, early intervention to control the situation is of utmost importance, even when the diabetes is mild or quiescent.

TREATMENT OF DIABETES OF THE OLD AND OF THE YOUNG

There is a basic difference between diabetes in the young person and that in the older person. A young diabetic is likely to experience progression over a period of years to a more severe diabetes, and to require more and more insulin; whereas the older diabetic's condition is likely to remain stationary, and he may even require less and less insulin as time goes on. In patients of the latter category, the diabetes usually is mild, and with any reasonable care, they do well. They do not require such close supervision as do the children. Some require no insulin at all, but only a slightly restricted diet.

Diabetes is a much more serious problem in children than in adults. The diabetic child has a longer span of disability to face. The various infectious diseases of childhood are likely to upset his diabetic status. A young child often does not understand the importance of the close supervision and self-discipline required, and may break the rules, and get into difficulty. Sometimes he is resentful of being a diabetic, and of being deprived of some of the privileges of his non-diabetic friends. The psychologic problems involved in such a situation require psychologic handling.

The routine management of diabetic children (and also adults) must be made as simple as possible, so that their burden will not be greater than is actually necessary. The diet should be adequate and satisfying. To give a child in-

sufficient food or too much insulin, so that he is thrown into hypoglycemia, which creates extreme hunger, is to force the child to steal food. In doing this, he is merely following a physiologic law of self-preservation, for at such times, he must have food in order to survive. If the diabetic child receives enough food to satisfy him, and the insulin dosage is adjusted so that he does not develop hypoglycemia, he presents few, if any, problems.

It has been my experience that children who were difficult to control during their early school years become much easier to manage when they reach university and the time of reasoning and responsibility. They want to accomplish something in life, and they know that in order to do this, they must take good care of their diabetic condition so as not to lose time in school. Some girls whose care was a difficult problem in childhood improve greatly when they reach their teens and become interested in the boys. Then they want a good figure, and so are willing to lower their food intake for this reason. From then on, they cause little or no worry to the physician. In such cases, often insulin dosage can be lessened, and the patients begin to carry normal blood sugars.

PREGNANCY

Pregnancy presents a greater hazard, both to mother and child, than in a non-diabetic. The incidence of stillbirths in diabetic women is large. A diabetic woman who becomes pregnant should have close medical supervision during pregnancy, to make certain that her blood sugar level throughout the day is nearly normal. If she is allowed to develop hyperglycemia, this acts as an abnormal stimulus on the function of the pancreas of the fetus, which thus becomes hypertrophic, manufacturing excessive insulin to supply the combined circulation of the mother and the fetus. That the fetal pancreas does supply insulin to the maternal circulation is shown in the decreased requirement for exogenous insulin by the mother toward the end of pregnancy, and the increase in insulin requirement after delivery when the fetal insulin supply is removed. The infant with an overdeveloped pancreas, born of a mother whose diabetes has not been properly controlled during pregnancy, may have too much insulin for its own needs when separated from the maternal circulation. This may cause death from insulin shock shortly after birth. Pathologic sections of the infant's pancreas in such instances show hypertrophy of the islands of Langerhans. The responsibility for protecting both mother and child to prevent such occurrences rests with the doctor. Since the knowledge regarding this is well established, it is justifiable to consider lack of adequate protection

of diabetic mothers during pregnancy as evidence of malpractice.

INSULIN REQUIREMENT

The insulin requirement differs in all diabetics. No mathematical rule can be applied, for each individual diabetic is a law unto himself. The dosage has to be calculated individually in each case and changed according to varying needs, which sometimes demand an increase, and sometimes a decrease.

What criterion should be used in determining the insulin dosage necessary to prevent the progression of diabetes? If a diabetic patient is hyperglycemic during most of the twenty-four hours, his diabetes will become more and more severe with time, since the insulinogenic apparatus will undergo further destruction, and hence less endogenous insulin will be available. After each meal in a normal individual there is an elevation of blood sugar, more in some, less in others. The maximal duration of such a postprandial hyperglycemia is two hours. Thus for the three meals, a normal individual can carry hyperglycemia for six hours a day, or approximately one fourth of the time. In any treatment of diabetes, whether by diet alone or diet and insulin, this fact furnishes a valid basis or standard of evaluation. If a diabetic patient has hyperglycemia only 25 to 30 per cent of the time, he is under good control, and the treatment he is receiving is adequate for his needs. If the patient has hyperglycemia more than 30 per cent of the time, then he is not well controlled, and readjustment in the routine is indicated.

A check of the blood sugar before each meal yields the necessary information for this evaluation. Since the period between meals is three to four hours, the blood sugar should return to normal during that time. Thus if the blood sugar is normal before breakfast, if it is normal or nearly normal before lunch and dinner, and the patient is not having any reactions, his diabetic condition is well controlled. If, on the other hand, the fasting blood sugar is normal, and the noon and evening blood sugar high, then treatment is not yielding satisfactory results. In such a case, the patient has hyperglycemia eighteen to twenty hours of the day, or approximately 70 to 80 per cent of the time. These facts show that determination of the fasting blood sugar alone is inadequate for proper evaluation of the diabetic state, and may actually be misleading.

In regard to glycosuria, the ideal is to keep the urine sugar-free throughout the whole twenty-four hours, but this ideal is not always attained. The best information obtainable from urine examinations is to determine how many grams of sugar the patient is losing each

twenty-four hours. If it is 10 grams or less, control is satisfactory; if it exceeds 10 grams, then a readjustment in the therapeutic routine is necessary.

In some instances, the excretion of sugar in twenty-four hours is more than 10 grams; it can reach 50 or 70 grams, and yet all three blood sugars during the day may be normal. In such a case, there is nothing to be done, for the patient has a low renal threshold for sugar and excretes sugar throughout most of the twenty-four hours. Such a renal threshold can not be changed. Increase in the insulin dosage will not decrease the glycosuria, and will only cause the additional difficulty of insulin reactions. With such patients, the large excretion of sugar in the urine must be accepted as normal, and the blood sugar level must be the sole criterion used in evaluating the diabetic condition. In all instances, of course, this is the only safe measure of insulinogenic function, for in 95 per cent of patients, if the blood sugar is normal, glycosuria is automatically eliminated.

VARIOUS TYPES OF INSULIN

When insulin was first discovered, twenty-five years ago, there was just the one type. Its action was rather brief, lasting three to four hours and requiring two to four injections daily. We learned how to use it, and in time obtained good results. Then, some years later, came the discovery of protamine zinc insulin, whose action was prolonged to twenty-four hours. This constituted a great advantage, as it meant that one injection was sufficient for the whole day. It was a special boon in the treatment of little children, who had previously had to take three and four injections daily. It reduced insulin reactions tremendously, although it did not eliminate them entirely. However, it had certain disadvantages. Since its action was prolonged, it was also slow in beginning. The delay of three to four hours before it began to take effect was a definite disadvantage, for during that period, following breakfast, the blood sugar had an opportunity to rise, and then once elevated, frequently remained high, sometimes until evening. In attempting to overcome this difficulty, protamine zinc insulin was administered both morning and evening, with varying results. However, this was not a satisfactory answer to the problem, because the patient was still requiring two injections a day. The next step was to try the combination of insulin and protamine zinc insulin, at first in two separate injections, later combined in one injection. This produced very good results, if proper combinations were effected. In such a mixture, the insulin starts its action immediately, thus preventing hyperglycemia following breakfast; and about the time its action is completed,

the protamine zinc insulin becomes effective and acts continuously until the next morning.

Occasionally, patients have an abnormal sensitivity either to insulin or protamine zinc insulin. Unless the allergic reaction is too severe, it is wise to continue the administration of protamine zinc insulin for a few days, since most patients will desensitize themselves by taking it. If the reaction does not disappear after four to five days, or is of alarming severity, then various other types of insulin are tried, in order to determine exactly the allergen that is causing the difficulty. These other types include crystalline insulin, zinc insulin crystals, pure beef or pure pork insulin. Globin insulin is another type of insulin now widely used.

This multiplicity of insulins, while good in the hands of experienced workers, leads to much confusion in the hands of general practitioners, who actually treat most patients with diabetes. It is my opinion that if a physician learns to work with insulin and protamine zinc insulin, he can accomplish all that can be accomplished with any of them. It is extremely unwise to attempt to experiment on patients with various insulin products, unless adequate laboratory facilities are available. Without strict laboratory control, one is working more or less in the dark with an unfamiliar product, and is not accomplishing anything constructive.

COMPLICATIONS

The two principal complications which upset the diabetic state are infection and ketosis. A disregard of therapeutic routine also will cause a relapse.

Infections nearly always disrupt a well-controlled diabetic state. The blood sugar increases; insulin dosage has to be stepped up and kept high until onset of insulin reactions indicate that it should be lowered. During infection, the effect of insulin is decreased. The reason for this is not known. It may be due to swelling of the beta cells in the islands, thus reducing the amount of endogenous insulin available to the patient during that period, or it may be a chemical inhibition or blocking of both endogenous and exogenous insulin, or it may be caused by some other factor. Although we do not know the mechanism of this effect of infections on the diabetic state, we do know certainly that, in the presence of infection, we have to act, and act quickly, to compensate and repair the damage. We have to increase the intake of exogenous insulin as much as is needed for the control of the hyperglycemia, in order to preserve the function of the pancreas and prevent serious progression of the diabetes. Furthermore, if we do not control the hyperglycemia, the patient is likely to go into acidosis and even coma, as the result of the infection.

This is true both of mild and severe diabetics, and a change into coma may occur rather rapidly.

Diabetic coma is usually due either to disregard of treatment routine or to infections. Its appearance requires prompt action. Elaborate reports of the blood chemistry are not necessary right at the start. Doing something for the patient is far more important. If blood can be secured for these determinations, so much the better. However, the physician should be able to recognize coma clinically. The patient is dehydrated, vomiting, has a parched, dry tongue, and is breathing heavily and slowly (Kussmaul breathing, so characteristic of this condition). About the only other cause of unconsciousness in a diabetic, barring an accident, is a severe insulin reaction, and this condition presents a quite different picture. The patient is drenched in perspiration, the breathing is normal or rapid, the tongue moist. These are the main differential points. In an occasional case, it may be difficult to differentiate between the two. In such an instance, 10 cc. of sterile, 50 per cent glucose solution should be administered intravenously. If it is an insulin reaction, the patient will recover in about five to ten minutes. If it should prove to be coma, no harm has been done, and the routine treatment for coma can be instituted.

The principal requirements in the treatment of diabetic coma are (1) plenty of insulin; (2) adequate liquids, administered intravenously or subcutaneously; (3) aspiration and lavage of the stomach, which usually is filled with an accumulation of undigested food from the past day or two. In washing the stomach, only a small amount of alkali should be used in the fluid, and the last bulbful should be left in the stomach after the washings become clear. In this way, additional fluid is furnished to the body, and once the stomach is rid of the undigested food, it is not likely to give rise to any vomiting. The patient will absorb it, and thus derive benefit from this additional fluid.

As soon as coma is recognized, 40 to 60 units of insulin should be given immediately. Then the patient should be transferred into the hospital. At least 40 units should be administered at half-hourly or hourly intervals, until the blood sugar begins to drop to about 250 milligrams per cent, when the intervals are lengthened and the insulin dose reduced. I have nearly always used 10 per cent glucose solution in normal saline intravenously at the beginning, 250 to 500 cubic centimeters at a time. Usually two to three such doses were adequate. At times I have used normal saline hypodermoclysis in addition. I do not believe that a patient in diabetic coma has to be drowned in fluids, with amounts of 5,000 to 10,000 cubic centimeters, as some men advocate. The main thing is to lose no time, to

work systematically by the clock so that no time is wasted in bringing the patient out of coma as quickly as possible. However, when this is accomplished, the problem is not ended. There can be no relaxation of the routine, for the patient can drift back into coma, and then the whole process has to be repeated from the beginning. Furthermore, if such a relapse is allowed to occur, the hazard to the patient is greatly increased.

When the patient has emerged from the coma, the next thing is to adjust the insulin to the new state of affairs. This has to be carefully calculated. Usually a considerable increase in the insulin dosage will be required. This increase may be but temporary, although in most instances, it is permanent. Diabetic coma is a major medical emergency, and it must be considered in that light.

A surgical operation might be considered as a complication of diabetes. It requires careful medical supervision of the patient so that he does not drift into acidosis or coma, which represents a serious emergency under such circumstances. If a patient is well controlled, and the administration of insulin is carried out faithfully during and after the operation, upsets are rare. A diabetic patient today can undergo a major operation with a feeling of safety practically equal to that of a non-diabetic.

Treatment of Pruritus Ani

Since early 1946, we have been using a medical routine aimed at reducing the pH of the rectal mucosa. This includes an acid-ash diet, glutasin capsule (a form of glutamic acid hydrochloride in combination with pepsin). Gelatin suppositories containing beta-lactose, may be dispensed by any pharmacist. The diet of itself reduces the pH, the glutasin acting as hydrochloric acid when administered orally, aiding in this process. The lactose suppositories tend to prevent the seepage of rectal discharges of a high pH from leaking out during the night.

Local care of the pruritic zone is of paramount importance. Following evacuations we advise the use of cotton pledgets or "kleenex", using a boric saturated solution so as to remove any secretions that have accumulated. The area is kept thoroughly dry with boric powder applied on a small piece of cotton which is changed frequently. Mercurochrome is applied to the region each day. We advise against soaps or ordinary toilet paper due to their irritating and traumatizing factors.—H. E. Bacon, M.D., and C. E. Hardwick, M.D., Philadelphia. The Journal of the Medical Society of New Jersey, Vol. 44, No. 11, November, 1947.

Surgical Treatment of Pain: A Diagnostic and Therapeutic Outline

OSCAR A. TURNER, M.D.

AS Thomas Lewis has written, pain, like similar subjective things, is known to us by experience and described by illustration. And because our knowledge of pain is derived in a large measure from human experience, knowledge which is difficult to submit to laboratory controlled investigation, clinically we tend to become overly objective and too little aware of the effect of constant and intractable pain on the patient. The treatment of pain has advanced so that at the present time there is scarcely any part of the body in which pain can not be relieved. Moreover, in none of the methods are mutilating and crippling procedures a necessary adjunct or result of the therapy. In the following resumé of the treatment of pain the discussion has been limited more or less to those instances where X-ray therapy will not bring the desired relief within the appropriate time, or where X-ray therapy is not indicated because of the etiology of the condition. It must be emphasized that these procedures should not be reserved for "terminal" cases but can be carried out during the early manifestations of pain, and thus avoid a long period of suffering and anguish for the patient.

Prior to any consideration of the indications for the various surgical procedures embodied in the treatment of pain, certain facts relative to the employment of each need be noted. No attempt has been made to discuss the technical aspects and only the broad implications are mentioned.

INTRATHECAL ALCOHOL INJECTION

While frequently a useful procedure, the results of intrathecal alcohol injection are uncertain at times and complications such as bladder and bowel paralysis and even meningeal irritation may occur. The procedure has a limited use and should be employed (1) when the pain is essentially unilateral, (2) when the pain is localized to the distribution of relatively few spinal segments, (3) when the patient's condition is such that possible complications as noted above are not materially significant, and (4) when the condition of the patient makes the use of other and more extensive procedures impractical.

It may be employed bilaterally, the two in-

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jections made at least 36 hours apart, but here the chances of complications are greater. It has been noted that injections of more than 8 minims of alcohol at the level of the second lumbar interspace will invariably cause bladder complications and that injections of more than twice that amount at the third lumbar interspace will cause rectal incontinence.¹ It is of importance that the distribution of pain be carefully studied and that the alcohol be injected in relation to the emergence of the nerve roots from the cord rather than their emergence from the spine.

CORDOTOMY

Cordotomy, or section of the anterolateral tracts in the cord, is the most satisfactory of all methods for the control of intractable pain in properly selected cases. It requires a relatively small laminectomy, can be performed under either general, local, or intravenous anesthesia, and is surprisingly well tolerated by the patient. Grant² has listed the advantages of cordotomy as follows: (1) A greater area of anesthesia can be obtained than by any other means; (2) pain and temperature sensations alone are obliterated while touch, position sense, and motor function remain intact; and (3) the operative procedure requires only a small laminectomy and does not exhaust debilitated patients.

It may be performed unilaterally or bilaterally. When performed at the level of the third or fourth thoracic segment, anesthesia as high as the ensiform cartilage may be obtained, but section of the tracts can be carried out as high as the sixth cervical segment when necessary.

Cordotomy is of particular value when the pain is secondary to a clinically stationary condition which does not affect the life expectancy. Under these circumstances, pain may be completely relieved without causing further disability

and allows the patient to lead a normal and useful life.

RHIZOTOMY

Rhizotomy, or section of the posterior nerve roots for the relief of pain, may be carried out alone or in combination with cordotomy or other necessary procedures. Its field of usefulness is confined to relatively localized lesions not involving more than four dermatomes and when the field of pain lies above the upper thoracic region. It is most useful in pain due to involvement of the cervical plexus or submaxillary region and for pain caused by carcinomatous involvement of the deep structures of the neck. The operative procedure is somewhat more extensive than that required for cordotomy since a larger laminectomy is required but probably causes little more exhaustion to the patient.

PRESACRAL SYMPATHECTOMY

Resection of the superior hypogastric plexus (presacral nerve) is a procedure which has a

wide field of usefulness, either alone or in combination with gynecological procedures.³ Resection of the plexus does not interfere with normal parturition, nor does it alter the normal menstrual cycle. It is not followed by any disturbance in the function of the rectum or bladder.⁴

SYMPATHECTOMY

Preganglionic denervation of the extremities should always be preceded by novocaine block as a therapeutic test. The technique has been carefully outlined by White and Smithwick,⁵ and it is emphasized that this must be carefully followed, particularly in the cervicodorsal region, if regeneration of the sympathetic chain is to be prevented. If relief is obtained for any significant length of time following sympathetic novocaine block, it may be advantageous to repeat the procedure prior to operation since occasionally the effects of the chemical sympathectomy persist.

DIAGNOSTIC AND THERAPEUTIC OUTLINE

I. PAIN OF FACIAL ORIGIN

The sensory innervation of the face and adjacent structures represents a complex anatomical and physiological system in which dysfunction may give rise to pain, which if not of complex character, is often of obscure origin. It is frequently difficult and even impossible at times to differentiate pain of facial and pain of cephalic origin, but such division may be purely arbitrary. Because of the complexity of the subject, in the following outline no attempt has been made to expand upon the diagnostic differences of the various types of pain, but merely to indicate the major features and the possible methods of treatment.

A. Primary trigeminal neuralgia. Paroxysmal, severe pain in V cranial nerve distribution. Frequently associated with a trigger point and painfree intervals.⁶

B. Secondary trigeminal neuralgia. In distribution of all or part of V cranial nerve. Pain may be similar to primary neuralgia, or relatively constant. Secondary to lesions of brain stem, neoplasms in relation to V nerve, or disease and infectious processes affecting trigeminal system.

C. Glossopharyngeal neuralgia. Counterpart of trigeminal neuralgia in IX cranial nerve. Pain involves tonsil, posterior pharynx, posterior portion of tongue, and middle ear. Precipitated by swallowing, talking, etc.⁹

D. Sphenopalatine neuralgia. A poorly defined syndrome: burning pain deep in cheek, behind and below eye with radiation toward vertex and occasionally into occiput, neck, and shoulder. Pain persistent and frequently associated with tenderness of involved areas.¹¹

E. Buccal Neuralgia. Superficial pain involving buccal area, constant and occasionally with trigger area. Within area supplied by sympathetic fibers associated with the facial artery and may involve lip, cheek, gums, nose, etc.

F. Geniculate Neuralgia. Involvement of the nervus intermedius. Includes paroxysmal geniculate neuralgia (involving region in front of ear and anterior wall of auditory canal), chronic neuralgia, and post-herpetic geniculate neuralgia. The first is usually due to chronic ear disease.¹³

G. Ciliary (Migrainous) Neuralgia (Harris). Boring or severe shooting pain in or behind eyeball. Probably due to vasomotor disturbance of meningeal vessels.¹⁴

H. Atypical neuralgia. Severe, constant, throbbing pains, may be ill-defined and often not conforming to anatomical distribution of nerves. May be due to eye-strain, dental infection, sinusitis, etc.

Alcohol injection or avulsion of terminal branches. Alcohol injection of major nerve trunks (except first division).

Intracranial section of V cranial nerve roots. Trigeminal tractotomy. Probably best reserved for first division involvement.

Treated as a major trigeminal neuralgia, or combined with other necessary procedures.

Intracranial section of the glossopharyngeal nerve.¹⁰

Cocainization of sphenopalatine area of diagnostic and often of therapeutic value.

Alcohol injection of sphenopalatine ganglion.

Novocaine or ammonium sulphate block of the external maxillary artery is diagnostic and may give persistent relief.

Resection of a segment of the artery (and associated sympathetic fibers) following diagnostic block.¹²

If treatment of the local disease gives no relief, intracranial section of the nervus intermedius may be done. (Probably of no value in the post-herpetic type.)

Primary treatment by histamine desensitization and cervicodorsal sympathetic block.

Avulsion of supraorbital and supratrochlear nerves may be of value. Sympathectomy if novocaine block affords relief.

Treatment of local condition and eradication of foci of infection.

II. PAIN ARISING IN CERVICAL REGION, NASOPHARYNX, AND ASSOCIATED STRUCTURES.

The extension of carcinoma of the face, neck, nasopharynx, or cervical region often involves regions supplied by several sensory systems. Concurrently, the pain is often most severe and persistent and the procedures necessary to obtain relief may be extensive. However, most of them, although technically difficult, are well tolerated by the patient and can be performed if necessary under a combination of local and intravenous anesthesia. Each case requires individual study to determine the extent of the pain and the type or combination of surgical procedure which will give substantial relief to the patient. The following outline indicates a few of the possible combinations or procedures which may be employed.

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| A. Painful carcinoma limited to the pharynx and posterior portion of the tongue. | Intracranial section of the IX cranial nerve. |
| B. Painful carcinoma of jaw, mouth, and/or pharynx, with involvement of the cervical region. | Intracranial section of the V and IX cranial nerves. Alcohol block of V cranial nerve may be carried out first to determine amount of pain due to involvement of the trigeminal area. If the cervical region is involved the above can be combined with cervical rhizotomy (upper 3-4 cervical nerves). ¹⁵ |
| C. Pain due to involvement of cervical region, cervical plexus, submaxillary structures, and deep neck structures. Pain in posterior aspect of head, below jaw, and in neck. | Rhizotomy of posterior roots of upper four cervical nerves. ¹⁶ |
| D. Superior laryngeal neuralgia. Severe paroxysmal pain over hyothyroid membrane, radiating upward or downward, and precipitated by swallowing, coughing, touching region of laryngeal nerve, etc. Trigger zone in pyriform sinus. ¹⁷ | Cocainization of pyriform sinus or novocaine block of superior laryngeal nerve gives temporary relief and is diagnostic.

Alcohol injection or resection of superior laryngeal nerve gives more lasting relief. |

Pain caused by metastatic involvement of the deep structures of the neck is rather commonly seen, and can be practically fully relieved by intradural posterior root rhizotomy of the upper 3 or 4 cervical nerve roots. The procedure is well tolerated and can be used in combination with section of any of the cranial nerves as noted above. Inasmuch as this type of metastasis is prone to cause pain long before a fatal termination from the primary disease, the procedures noted above are to be seriously contemplated when local X-ray therapy fails to alleviate the suffering.

III. PAIN IN UPPER EXTREMITIES

Pain involving the upper extremities varies little from that which has been discussed below relative to the lower extremities. What has been written concerning pain in amputation stumps, phantom limb, and herniated discs applies equally well to the upper extremities. The following additional cause of pain is referable to the upper extremities alone.

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| A. Compression of brachial plexus. Secondary to spasm of scalenus anticus muscle and/or cervical rib. Major manifestations may be secondary to involvement of the brachial plexus or the vascular system or both. | Novocaine block of the scalenus muscle itself may be diagnostic. Section of the scalenus anticus muscle gives permanent relief in most cases. Occasionally, resection of a cervical rib may be necessary. ¹⁸ |
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The control of pain secondary to lesions within the thoracic region has not been included in this review. Recent work has shown the efficacy of cervico-thoracic sympathetic block for the treatment of intractable pain due to aortic aneurism, severe angina, etc.⁵

IV. ABDOMINO-PELVIC PAIN

Abdomino-pelvic pain, when secondary to malignant growths, has been divided into three general types by Leriche.¹⁹ The first of the three types has been described as a localized, pre-vertebral pain which occurs secondary to invasion of lymphatics and lymph nodes adjacent to and adherent to the spinal column. This type is frequently observed following the removal of the primary malignant lesion, but characteristically from the beginning the pain is rather fixed and localized and rapidly becomes unbearable. In the dorsal region, as well as when the lesion involves the lumbar spine, the pain may take on the characteristics of sciatica, but this type of pain is most frequently seen in pelvic carcinoma where there may be compression or involvement of the lumbar plexus as it passes through the muscles of the pelvis. The pain is generally due to direct compression or involvement of nerve trunks or compression of the extra-spinal nerve roots.

The second type described by Leriche is the diffuse abdominal pain which he believes is secondary to periarterial and perisymphathetic lymphangitis. The pain is described as having a gripping character with occasional sharp attacks of lancinating pain with a rather vague localization. There may be associated functional disturbances, and this type of pain is frequently seen in abdominal carcinomas with recurrence after operation or in malignant tumors which have continued to develop despite deep X-ray therapy.

The third type was described by Leriche as being "spinal", and due to localized metastatic deposits in the vertebral column itself. This frequently follows removal of the primary growth

and begins after a period of freedom from pain, often first manifesting itself in a manner not unlike that of arthritis. The pain gradually becomes neuralgic and girdle in character and is frequently exaggerated by movement, particularly walking and bending. Eventually, it may assume the character of the first type described above, so that there are two phases in the development of the clinical picture. First a dull, piercing, continuous, and localized pain which is exaggerated by movement and later a rather typical girdle or radiating root type of pain secondary to involvement of the nerve roots by compression from either tumor or vertebral collapse.

Not all abdomino-pelvic pain is secondary to malignant growth and the following outline lists the characteristics of the major sites of origin and the general method of treatment of the pain.

ABDOMINAL PAIN

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| A. Pain secondary to abdominal and abdomino-pelvic malignancy (stomach, colon, pancreas, gallbladder, etc.) or to extension and metastases from pelvic growths. | Bilateral cordotomy in lower cervical or upper thoracic region. ² |
| B. Segmental abdominal pain. Localized hyperalgesic area associated with tenderness,—in absence of visceral disease. Peripheral neuralgia of lower intercostal and/or lumbar nerves. ²⁰ | Paravertebral dorsal or lumbar nerve block. Diathermy, etc., may give some relief in mild or early cases. |
| C. Pain in abdominal wall secondary to herpes zoster. Pain usually subsides with appearance of rash or shortly thereafter, but may occasionally become chronic and last years. | Paravertebral nerve block of involved nerves.

X-ray therapy to dorsal root ganglia. Chronic variety very difficult to treat and posterior root section may be necessary for relief in severe cases. |
| D. Pain of gastric (tabetic) crisis. Pain may be referred well up under the sternum. | Cordotomy, with rhizotomy of exposed nerve roots (usually T2-T6) on ipsilateral side. ²² |

PAIN OF PELVIC ORIGIN

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| A. Malignant tumors within the pelvis: (1) From uterine fundus, cervix, or vagina, with lateral spread into parametrial or paracervical tissues. (2) Bladder and prostate growths with extension into adjacent structures. (3) Sigmoid and rectal growths with regional spread. (4) Metastatic lesions in pelvic osseous structures. Regional spread or involvement of lumbosacral plexus may give rise to pain. | Bilateral cordotomy in upper thoracic region is the procedure of choice. In isolated instances intrathecal alcohol injection may be of value. ²¹ |
| B. Primary dysmenorrhea (functional), in absence of pathologic changes in the pelvic organs, or associated with but not necessarily secondary to demonstrable or corrective pelvic pathologic conditions. | Presacral sympathectomy. Procedure may be carried out in conjunction with correction of pelvic abnormalities to insure relief from pain. ^{3, 22} |
| C. Pelvic pain associated with painful bladder spasm or vague complaints referable to vagina or perineum. Often associated burning sensation in vagina, frequency, dysuria, and colpospasm. ⁴ | Presacral sympathectomy. (May give complete relief or materially lessen pain.) Intrathecal alcohol may be of value in some persistent and severe forms. |

V. PAIN INVOLVING THE LOWER EXTREMITIES

Persistent and intractable pain which occurs in the lower extremities may be a reflection of a purely local condition, of disease involving the pelvis and extending to involve the lumbosacral plexus or may be secondary to a generalized or systemic condition. Of the various causes of pain in the lower extremities, there are six general etiological groups in which surgical treatment may be necessary.

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| A. Pain due to involvement of the lumbar nerve roots or lumbosacral plexus from pelvic tumor as noted above. | Bilateral or unilateral cordotomy. In some instances, intrathecal alcohol injection may be used. ²¹ |
| B. Nerve root compression due to herniation of intervertebral disc, overgrowth of the ligamentum flavum, or involvement of the intervertebral canal by arthritic processes. ²³ | Decompression of nerve root by removal of disc herniation, ligamentum flavum, or unroofing of intervertebral canal by hemilaminectomy. |
| C. Causalgia and causalgic states secondary to injury to major peripheral nerve trunks. | Paravertebral sympathetic block. Repeated blocks may give some relief or be of diagnostic value prior to operation. Sympathectomy. ²⁴ |
| D. Painful amputation stumps and pain in phantom limb. | Local neurolysis may occasionally give some relief in causalgia but is usually not effective. |
| E. Neuritis and neuralgia of local or systemic origin,—i.e. diabetic peripheral neuritis, meralgia paresthetica, neuromas, etc. | Usually responds to treatment of systemic or local cause. May require local novocaine or ammonium sulphate block. Occasionally may require neurectomy. |

In reference to painful amputation stumps, certain facts are of interest. This pain may be confined to the stump itself or may be a sympathetic type of pain present in the absent limb. Although investigation invariably discloses the presence of one or more small neuromas, the neuroma itself is most often not the causative factor, and revision of the stump and excision of the neuroma will not give relief. Reference here is made to the constant, burning, paroxysmal type of pain and not to local tenderness and pain elicited by pressure on a superficially placed

neufoma. In the latter instance, excision of the neuroma and replacement of the nerve deeply within the stump will relieve the local tenderness.

In the presence of the sympathetic or phantom limb pain, reamputation, alcohol injection into the nerves of the remaining portion of the limb, resection of the neuroma, X-ray therapy, and local physiotherapy, such as diathermy, are procedures to be avoided.

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Löffler's Syndrome

Fifteen years have elapsed since Löffler described the symptom complex which bears his name. In 1940, when the following case was observed about 100 cases had been reported; 51 of these were included in Löffler's series of 1936, and few cases were to be found reported in American Literature.

The disease is characterized roentgenologically by a succession of transitory shadows which may appear in any part of the lung fields, be widespread and homogenous, spotted or cloudy, more or less sharply defined, may resemble tuberculosis or bronchopneumonia, and ordinarily do not remain in one spot for more than two weeks. As one shadow disappears, others may appear in different parts of the lung parenchyma. It is necessary to have serial roentgenograms made to be certain of the diagnosis.

The other characteristic finding is the blood eosinophilia, which varies from 8 or 9 to as much as 70 per cent. The eosinophilia may be present before the roentgen changes or may not appear until they are well established. It may disappear with the clearing of the pulmonary infiltrations or it may persist for some time after the disappearance of the infiltrations. The majority of Löffler's patients had some rise in temperature, seldom more than to 101 F. Other observers report cases in which there was an acute febrile reaction, some cough, and occasionally symptoms of pleurisy. Physical findings are generally completely absent, and even at the height of the infiltrative process there may be no rales, changes in breath sounds, or alterations in resonance.

It is now rather generally agreed that the condition is an allergic phenomenon and may be produced by many different allergens.—George T. O'Byrne, M.D., Corpus Christi, Texas. *Texas State Jr. of Medicine*, Vol. XLIII, No. 7, November, 1947.

The Virus of Poliomyelitis

The virus of poliomyelitis has been reported variously as ranging from 300 micromillimeters down to 8 mu. in diameter. The latest studies employing the most purified suspensions, give figures from 8 to 25 mu. Another interesting feature about the virus is that under normal circumstances it apparently carries a negative electric charge. Because the virus is eliminated in large amounts by way of the gastro-intestinal tract in recently infected individuals, its resistance to various substances and abnormal conditions has been studied widely. It seems to be quite resistant to numerous agents and has been kept for as long as eight years in glycerol in the cold. Ether does not destroy it nor do many contaminating microorganisms. In water and milk at room temperature, it survives for periods up to a month or more, and much longer when refrigerated. It is reported to be inactivated by heat between temperatures ranging from 50 to 55 degrees Centigrade for thirty minutes. Four parts of chlorine per million will destroy it in turbid water in twenty-four hours, while .5 parts per million, which is higher than the concentration usually employed by municipalities for making water potable, has not been found to destroy the virus in one and one half hours but did in four hours. These figures on chlorine do not necessarily mean that municipal chlorination is not effective, since dilution, oxidation, sunlight and soil as well as filtration processes are frequently at work and must be taken into consideration. Ultraviolet is also quite effective in destroying the virus. Virus badly contaminated by other microorganisms was first demonstrated to be capable of purification by the addition of ether without injury to the virus.—Ferdinand C. Helwig, M.D., Kansas City, Mo. *The Jr. of Missouri State Medical Association*, Vol. 44, No. 12, December, 1947.

Antithyroid Drugs and the Private Practitioner

ROBERT C. AUSTIN, M. D., EUGENE F. DAMSTRA, M. D., and ALVIN J. CARLSON, M. D.

OF the hundreds of antithyroid compounds tested in the past few years, the most promising have proved to be thiouracil and propylthiouracil. These two drugs have much the same effect except that propylthiouracil appears to be the less toxic, and for this reason requires less frequent checking of the patient's condition. Now that it has become generally available, therefore, it doubtless will be the preparation of choice in most cases. The private practitioner, especially, will appreciate relief from some of the burden of constant supervision.

Because the two drugs are so similar, a general familiarity with the advantages, limitations, dangers, and method of using thiouracil is a helpful preliminary to satisfactory management of propylthiouracil cases. It appears to us, then, that it will serve a useful purpose to supplement the many reports of laboratory and clinical investigations emanating from large institutions with an outline of the available knowledge presented from the rather neglected viewpoint of the private practitioner.

WHEN ANTITHYROID DRUGS SHOULD NOT BE USED

The outstanding fact which concerns the private practitioner is that all antithyroid preparations are dangerous drugs. None of them can be given safely unless the patient is under constant supervision, with regular and frequent checking. If, therefore, the patient lives at such a distance that adequate supervision is impossible, that patient should not be given any goitrogen. If the patient is not intelligent enough or not co-operative enough to follow instructions, it is not safe to treat him with such potent agents.

If, on the other hand, the physician is too overburdened or is unwilling to devote the time to frequent reports and the regular blood and other tests, that physician cannot safely prescribe thiouracil and related preparations. If the community is isolated and laboratory facilities are not available for diagnosis and follow-up, the physician should forego the use of these dangerous drugs, and should use a safer method of treatment or send the patient to a medical center where supervision can be given. The physician who is not thoroughly conversant with the major literature on the subject and has not mastered the technique of treatment with antithyroid drugs should abstain from their use.

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The period of experimentation and clinical trial has shown approximately what can be expected at least of thiouracil, and the method of using it has been worked out in some detail. If the approved methods are followed, serious difficulty is not likely to occur, although it is impossible ever to be certain that agranulocytosis will not develop suddenly. There are still some unknown factors, but fortunately, these are not matters vital to the private practitioner, for it is beyond his scope to decide them.

COMPLICATING CONDITIONS

Despite the difficulties and dangers of antithyroid medication, these drugs have a distinct field of usefulness for the private practitioner. For thyrocardiacs and diabetics, and others with complicating diseases which increase risk of operation, thiouracil has been of great benefit. Even severe cardiac disease often may be improved by relief of thyrotoxicosis, and in some cases auricular fibrillation and paroxysmal auricular flutter have completely disappeared during treatment with thiouracil. The drug has been used with good results in angina pectoris. Relief from symptoms coincides with reduction of the metabolism to subnormal. While some failures have occurred in cases of diabetes, many diabetics have been relieved of their glycosuria, in keeping with observations following thyroidectomy. In

greatly debilitated and elderly patients who are not fit subjects for operation, the antithyroid drugs may be life-saving. During more or less prolonged administration, it may even be possible so to build up these patients that permanent relief can be secured by thyroidectomy. When other operations are indicated in patients with a complicating hyperthyroidism, it may also be possible to keep the thyrotoxicosis in check so that the patient may be in better condition for surgery. Other types of cases in which the goitrogens are recommended are those with an idiosyncrasy to iodine, those that are iodine-fast, and those with concomitant tuberculosis. Even regression of a psychosis has been reported. A favorable report, however, on thiouracil in ulcerative colitis without hyperthyroidism has not been confirmed by subsequent trials.

In acute infections not accompanied by a decrease in granulocytes there would not appear to be any reason to withhold thiouracil, although it has been suggested that a sulfonamide be substituted, since the sulfonamides are both bacteriostatic and goitrogenic. In infections, such as influenza, in which the granulocytes are reduced, thiouracil undoubtedly should be discontinued, and penicillin or streptomycin be administered for secondary bacterial infections, rather than a sulfonamide. None of these preparations, of course, are effective against the influenza viruses. Iodine may be substituted for the thiouracil, if necessary, during the course of the infection.

PREGNANCY

Until more is known about the effect of the antithyroid drugs in pregnancy, it seems best to avoid giving them in this condition, as well as during lactation. In experimental animals, the concentration of thiouracil in the fetus is half that in the mother, but the young apparently are normal at birth except for hyperplastic thyroids. By the tenth day, retardation in development becomes evident, probably because the concentration in the mother's milk is very high—about three times that in whole blood. Reports on human cases have differed. The mothers, so far, have come through in good condition. Sometimes there appear to be no deleterious effects on the child, especially when iodine is substituted for thiouracil during the last month of pregnancy. Again there is transient enlargement of the thyroid or even some retardation in development. During lactation the mother should be taken off of thiouracil; otherwise she should not nurse her child.

TOXIC EFFECTS

Comparative figures on the many varieties of toxic reactions produced by administration of antithyroid drugs are: Thiobarbital 28 per cent,

thiouracil 13.5 per cent, and propylthiouracil 2 per cent.

The reactions reported from thiouracil have included fever with and without apparent infection, sore throat with general malaise, gastrointestinal disorders, edema of lungs and of extremities, ophthalmic symptoms such as conjunctivitis and cellulitis, skin reactions such as urticaria, dermatitis, or drug eruption, oral infections, parotitis, thyroiditis, and arthralgia. Jaundice, purpura, splenomegaly, liver damage, crystalluria, hematuria, and uremia have also been reported. One of our patients developed vaginal ulcers coincident with ulcerative sore throat. Many of these reactions probably are allergic, since the symptoms disappear after the drug is withdrawn, but may recur when only a minimal dosage is resumed. Sometimes they subside even though treatment is continued, especially if the dose is reduced. Because the incidence of allergic symptoms is greater when administration is intermittent, thiouracil therapy generally should not be interrupted except for severe or long-continued reactions.

Weight for weight, propylthiouracil is more toxic than thiouracil, but it is so much more potent that smaller doses can be given. Toxic effects observed so far have been much less than with thiouracil, although cases of agranulocytosis have been reported, and the suspicion is therefore growing that the drug is not quite so harmless as was first believed.

NEOPLASMS

The combined administration of allyl-thiourea and a carcinogen (2-acetyl amino-fluorine) has produced both benign and malignant tumors of the thyroid, although new growths so far have not been stimulated by either substance alone nor by any other antithyroid substance. The physician, however, should be alert to detect cancer, especially in older persons, which might be produced by the combination of a goitrogen and some carcinogen present in the body. These drugs should not be used for medical treatment of adenomatous goiter because of a possible increased carcinogenic tendency in this type of gland. The precaution does not apply to pre-operative therapy, since the period of administration is shorter, and is followed by extirpation of the gland.

CRYSTALLURIA

Thiouracil and other goitrogens are excreted chiefly through the kidneys, and one of the most serious conditions they cause is precipitation of crystals in the kidney tubules, resulting in hematuria or even uremia. The routine use of sodium bicarbonate has been suggested to prevent this condition. Probably, however, alkalization is an advantage only when the urine is hyperacid,

since thiouracil is soluble at its normal pH. Adequate fluid should always be supplied to keep the compound in solution when passing through the kidneys.

RETICULO-ENDOTHELIAL REACTIONS

The reticulo-endothelial system is especially sensitive to these drugs. All types of blood cells have been affected in one case or another, but the most serious difficulty is caused by agranulocytosis. Many lives have been lost because of infection resulting from lack of these phagocytic cells. The reason for the toxic effect on blood cells is not too well understood, though doubtless it bears some relation to the fact that the highest concentration of thiouracil in the body is found in the bone marrow. It also may be related to the fact that *in vitro* the respiration of bone marrow and especially of myeloid elements, is retarded by high concentrations of thiouracil.

PREVENTIVE MEASURES

To the private practitioner even more than to the large institution it is important to prevent these dangerous toxic reactions. No sure preventive has yet been discovered, but we know that the transition of developing blood cells from one stage to another requires various substances at different levels, as, for example, iron or the anti-pernicious-anemia factor. Spies and his coworkers have reported recently that both folic acid (one of the B vitamins) and thymine (one of the nucleotides found in thymo-nucleic acid) have anti-anemic properties. Other B vitamins are known to be essential, possibly all of them, and probably ascorbic acid. Some of the hormones are also believed to be required. If we knew all of the essential substances, we could supply them in quantities that might be sufficient to prevent toxic blood-cell reactions. As it is we can at least supply adequate B and C vitamins, sufficient protein, with iron when indicated, together with the copper which is believed to be an enzyme active in iron metabolism.

Hyperthyroid patients, despite their typically large appetite, usually lose weight. They not only burn up an abnormally large amount of carbohydrates, but when they run short of fuel foods they start to use up the body proteins. They rarely ingest enough of the B vitamins, known to play a part in carbohydrate metabolism, to supply the increased demand. When these vitamins are insufficient, liver damage occurs and the patient loses weight. Several cases of liver damage by thiouracil also have been reported. Since this organ has been protected from damage by other toxins, such as the carcinogen butter yellow, by B complex and casein, it seems quite rational to use a high-protein,

high-carbohydrate, high-vitamin diet, with such supplements as may be indicated, to protect from damage by the antithyroid drugs as well as by hyperthyroidism.

TREATMENT OF AGRANULOCYTOSIS

Agranulocytosis appears suddenly and may develop at any time during treatment, from a few days to many months. When this condition supervenes, the antithyroid drug must be stopped immediately, and transfusions of fresh whole blood should be started. Penicillin is given in divided doses totaling 500,000 units daily to combat infection until the bone marrow recovers. No sulfonamide should ever be given since drugs of this classification depress the bone-marrow activity. Acetanilid, aspirin, and the various other coal-tar derivatives so frequently given to relieve the discomfort of infections, are also contraindicated, as they too retard formation of blood cells. Pentnucleotide, liver extract, pyridoxine hydrochloride, and folic acid have all been reported to be helpful, and might well be supplemented by massive injections of crystalline B vitamins. After the patient returns to normal, antithyroid treatment may be cautiously resumed.

DOSAGES AND SUPPLEMENTAL THERAPY

The antithyroid drugs are preferably given in divided doses, four times daily, in order to maintain a constant blood concentration.

The daily dosage of thiouracil usually is 0.6 gm. until the basal metabolic rate falls to normal. After that 0.1 or 0.2 gm. is given for maintenance. Some clinicians reduce the dosage to 0.4 gm. daily when the basal metabolic rate falls halfway to normal and others prefer to start treatment with this dose, feeling that 0.6 gm. is too much. We find that, as with other drugs, patients differ in their response. An occasional patient requires more than 0.6 gm. initially; others get along well with less. It is a good rule to give the smallest dosage that will produce satisfactory results, based on clinical symptoms, pulse rate, and basal metabolic rate. The reason for this is that there are more toxic reactions, and the toxic reactions are more severe, when the dosage is large than when it is small.

The optimum dosage of propylthiouracil has not yet been so definitely determined. It is our practice to start with 75 to 100 mg. in mild cases, increasing the dose as needed to produce a satisfactory reduction of the basal metabolic rate. Severe cases require as much as 200 or even 300 mg. to start. This may be reduced to 100 mg. when the basal metabolic rate has declined halfway to normal, and again reduced to a maintenance dose of 50 mg. when the basal metabolic rate reaches zero.

In medical cases, administration of antithyroid drugs should be continued for a year or more.

Surgery is usually indicated if there is a recurrence of symptoms. In surgical cases, in order that there may be no danger of toxic reactions during convalescence, it is our custom to discontinue the antithyroid drug two weeks before operation, and start the patient on Lugol's solution, 30 drops daily. This brings about involution of the gland, and reduces friability and vascularity.

If exophthalmos or edema are troublesome, desiccated thyroid, one or two grains daily, may be given concurrently with the goitrogen. This counteracts the effect of the pituitary thyrotropin, and so increases the patient's feeling of well-being as to compensate for the slight increase it produces in metabolism.

Because of the reactions produced by antithyroid compounds, we consider it better practice not to subject to the dangers inherent in their use any patient who can be treated successfully without them. For this reason we use only iodine preoperatively in cases of mild Graves' disease in which the basal metabolic rate can be brought down to near normal without use of the new drugs. Before thiouracil, thyroidectomy was commonly done when the basal metabolic rate had declined halfway to normal. With thiouracil or propylthiouracil, however, it can and should be brought completely to zero. The operative and postoperative courses then are much smoother, and for this reason, in moderate or severe cases we prefer preparation with one of these drugs plus iodine.

FOLLOW-UP

The constant, never-failing, meticulous follow-up required in antithyroid treatment calls for patience and cooperation on the part of both physician and patient. When treatment is started, it is well to lay out, with the patient's help a plan for regular visits and regular tests to assure his safety. The dangers should be explained to him, and he should be taught that regular return visits are as essential as regularity in taking the prescribed medication. The physician must assure himself that the patient understands thoroughly what he is to do, and that his safety depends on his cooperation. He should also be taught to report at once in the event of a sore throat, general aching, or other signs of agranulocytic angina. When the patient is on thiouracil, a complete blood count should be made weekly; when he is on propylthiouracil, it should be made every two weeks until the basal metabolic rate reaches normal, and less frequently thereafter. Metabolism estimations are made every two weeks to a month. In the interval between laboratory tests, a very good estimate of progress may be obtained by observation of the thyroid gland, eyes, pulse, weight, and skin, and of the pa-

tient's behavior, appearance, and general condition.

SURGICAL CONSULTATION

Before preoperative treatment is started, we urge preliminary consultation with the surgeon, especially in doubtful cases. Otherwise it may be necessary to discontinue therapy for a time to be sure that thyroidectomy is indicated. The antithyroid drugs should not be used as a therapeutic test for hyperthyroidism; the diagnosis should be made accurately by other means before treatment is started.

During the early clinical trials of thiouracil, some patients were referred to us who apparently had been hypothyroid but were given the drug in the vain hope that it would reduce the size of the goiter. One case referred to us for thyroidectomy with a diagnosis of Graves' disease did not seem quite typical. The patient had been on thiouracil for a considerable time, and had already entered the hospital, but we decided to defer operation and discontinue thiouracil. After she had been off the drug for several months we became convinced that she had only a small colloid goiter, had originally been hypothyroid, that her symptoms were of neurotic origin and that operation would be detrimental. Had thyroidectomy been indicated, however, valuable time would have been lost while the diagnosis was tested.

SUMMARY

Antithyroid drugs are considered from the standpoint of the private practitioner. They are very useful but also very dangerous, and it is the prevention and treatment of toxic reactions that give the private physician his greatest concern.

Contraindications, complicating conditions, toxic reactions and their treatment, preventive measures, dosages, adjuvant therapy, and other pertinent considerations are discussed.

Penicillin in Syphilis

A schedule of mapharsen, penicillin, and bismuth has replaced all other rapid treatment methods for early syphilis.

In the treatment of latent syphilis, the same schedule can be used, and it is possible that the results may be as good as the older method of continuous arsenicals and bismuth given over many months.

In the treatment of cardiovascular or visceral syphilis, a course of bismuth and potassium iodide should precede the administration of penicillin.

The results of penicillin therapy in seronegative primary syphilis and in syphilis in pregnancy are especially brilliant, and these results alone are enough to give penicillin a high place in the treatment of this disease.—S. E. Sweitzer, M.D., *The Diplomat*, Vol. 19, No. 6, Oct., 1947.

Present Status of Vagotomy

HAROLD C. KLEIN, M.D.

THERE has been a crying need for a new approach to the "ulcer problem". Medical measures have failed to prevent periodic recurrences although they cope rather successfully with each acute flare up. The nature of ulcer genesis is so bound up with emotional build and situational response that diet and medication fall far short of capably handling the problem as a whole.

About 10 per cent of peptic ulcer sufferers will not respond to a medical regime. These are the intractable cases whose social and economic activities are limited by plaguing symptoms. Another 10 per cent develop frank surgical complications such as acute perforation, pyloric obstruction, and repeated hemorrhage.¹

The surgical methods at our disposal leave much to be desired. Gastro-enterostomy fulfills neither its physiologic nor practical promises. After gastro-enterostomy, if the stoma remains patent, a duodenal ulcer will heal, but in about 34 per cent of cases, anastomotic ulcer is produced.²

Subtotal gastrectomy is a more extensive and hazardous procedure. Properly performed, it will effect a cure for gastric or duodenal ulcer. However, in the operations on duodenal ulcer, a fair number (2 to 8 per cent) can be expected to develop ulceration at the anastomosis.^{3, 4} Approximately 15 per cent of all those operated develop "dumping syndrome" or a variation of it; intractable anemia, asthenia, and failure to gain weight.⁵ Gastro-intestinal bleeding is also a frequent sequel to the operation and may be due to stomal ulcer or secondary ulcerative, hemorrhagic gastritis.

Cutting the vagus nerves to the stomach, the newest surgical maneuver proposed in the management of peptic ulcer, is now being subjected to close scrutiny and evaluation.

BACKGROUND

It has long been noted that exacerbations of ulcer activity are related to periods of emotional stress. Cushing established the relation between duodenal ulcer and cerebral function.⁶ Pavlov implicated the vagus nerves as a pathway from brain to stomach. He showed that by cutting these nerves in dogs, he could abolish the gastric reaction to sham feeding.⁷ Stahnke stimulated the vagi electrically and two of his five animals developed peptic ulcer.⁸ Hartzell, also working on dogs, noted reduced gastric acidity

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and motility after vagus interruption.⁹ Dragstedt could reduce the volume of acid output over a 24-hour period with vagotomy in dogs by 1/10th to 1/50th, indicating that the nervous or cephalic phase of gastric secretion is 10 to 50 times as effective as the chemical phase.¹⁰ Beaver and Mann prevented the development of the expected ulcers by cutting the vagi in their Mann-Williamson dogs.¹¹

These and other corollary findings indicated that the vagus nerves affect gastric secretion, gastric motor activity, and constitute a major pathway between psyche and soma. These three factors, singly or in combination, are believed to play a dominant role in the pathogenesis of peptic ulcer. Severance of the vagus nerves should, therefore, materially alter the development, progression, and healing of ulcer. The idea of vagotomy as a therapeutic measure is not new,^{12, 13, 14} but complete section of all the fibers high above the stomach was not fully explored until Dragstedt and his associates started their work about five years ago.^{15, 16, 17}

DEVELOPMENT OF THE PROCEDURE

Because of Hartzell's contention that unless a complete vagotomy was performed, the results would be unsatisfactory, the early investigators were prompted to approach the nerves through the chest where the trunks are less divided and more readily accessible. The results of the early series of operations, as far as ulcer healing was concerned, were excellent. Three major difficulties, however, soon became apparent: Operations within the thoracic cavity were beyond the scope of the smaller hospitals and clinics; the lesion under treatment was inaccessible to direct examination at operation; severe and unrelenting gastric dilatation and retention developed in as many as 50 per cent of the cases. Of the three, the latter was by far the most serious.

Many of those who developed retention were more miserable with it than they had been with their ulcer. One of Bockus' cases, for example,

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was unable to empty his stomach without urecholine nine months after transthoracic vagotomy despite the return of his acid secretion to the preoperative high levels.¹⁸ It was even necessary to perform a gastro-enterostomy or a subtotal gastrectomy on a good number of this group to make them comfortable. Many are still dogging the clinics, pleading for relief from the severe bloating and foul belching. Because of the severity of this complication, some of the investigating groups condemned vagotomy as a failure.

In an effort to improve an otherwise successful method, the transabdominal approach was devised. Entering through an abdominal incision, the lesion could be directly examined, the degree of surgical difficulty reduced, and a concomitant gastro-enteric anastomosis to abort gastric retention could be performed. Thus, the most important defects in the procedure could be remedied.

The question was raised as to whether all fibers of the nerves could be reached from an abdominal approach. By the maneuver of freeing the lower esophagus to which the vagus trunks are adherent, and pulling it down into the abdomen, the nerves are cut at a supradiaphragmatic level. The incidence of complete vagus interruption is apparently as high with this technique as it was with the transthoracic approach. Although some men, notably Moore in Boston, still favor going through the chest, the abdominal operation done in conjunction with gastro-enterostomy or subtotal gastrectomy is currently the most accepted method.

RESULTS OF VAGOTOMY

In evaluating results, it is of paramount importance to know whether or not the vagus nerves have been cut completely. Incomplete vagotomies in the past have generally been unsatisfactory. Although they may be attended by healing of the ulcer, recurrences can and do occur. Recent studies report an 8 per cent variation from the usual course and distribution of the nerves above the diaphragm.¹⁹ Other anomalies may exist to prevent surgical severance of all the fibers. The inclusion of the cases of incomplete vagotomy with the complete tends to confuse the reports of results and undoubtedly accounts for some of the discrepancies.

At present, the insulin test, as developed by Weinstein, Hollander, and their associates,²⁰ is the only method available for determining the completeness of vagus disruption. The test is based on the fact that the secretory response to hypoglycemia induced by insulin is mediated through the vagus nerves. This response is lost when all vagal fibers have been cut. It is assumed therefore, that no reaction to insulin hypoglycemia after vagotomy is evidence that the procedure is complete, while a positive response

indicates that some fibers have been missed* and are maintaining the vagal function.

Although the insulin test offers valuable information, it is not entirely dependable because it is based on so many variables. The response to a fixed dose of insulin varies with the individual as does the level of hypoglycemia necessary to produce a secretory rise. A difference of opinion also exists as to the exact criteria for a positive test. Other discrepancies have appeared. An occasional case retains a positive test despite extensive exploration above and below the diaphragm for prodigal fibers, or, a negative test may appear following an incomplete section of the vagi. With these factors in mind, the reported results of vagotomy may be more fairly evaluated.

Secretory: The effects of vagotomy on humans have borne out much of the earlier work on dogs. In about 80 per cent of duodenal ulcers, there is a fasting hyperacidity, approximately twice the normal volume of night secretion, and a sharp response to insulin induced hypoglycemia. Although the secretory changes after vagotomy are difficult to catalogue because of the altered mechanics of the stomach, generally the following changes are noted: there is a lowering of the acidity or a complete absence of hydrochloric acid in the fasting specimen; there is a return to a normal volume or an absence of free acid in the night secretion; there is a loss of response to insulin hypoglycemia.^{21, 22, 23, 24, 25} In many cases, the low acid figures after operation tend to return to normal or preoperative levels within a year's time, although some do not.²⁵ Vanzant has shown a similar return in dogs.²⁶

Motor: Vagus interruption produces a lessening of gastric tonus and motility with retention of stomach contents.²⁷ Other studies indicate that there is also some degree of failure of the pylorus to open.²¹ Balloon-kymograph and roentgen studies reveal that the stomach regains much of its tone and motor power in about one year, although, in some, there can still be found a small six-hour residue of barium.^{21, 28}

The gastric retention secondary to motor failure is of varying severity, often posing a serious postoperative problem, particularly when vagotomy is done as a lone procedure without supplementary gastro-enteric anastomosis. The loss of muscular activity is greatest directly after operation so that the immediate postoperative care of the vagotomized patient is most important. If the stomach is permitted to balloon up to immense proportions, it apparently has the greatest difficulty in ever regaining a normal motor function. A careful regime of constant tube decompression is effective in avoiding this hazard. If the stomach is kept empty by continuous suction during the first four to five days, and at frequent intervals thereafter until

it has regained enough of its power to prevent the danger of overdistention, the late severe effects of gastric retention do not develop.

Urecholine (Urethane of B-Methyl Choline) will stimulate gastroduodenal peristalsis and is an effective agent in the management of retention if it exists.^{28, 21}

Sensory: Although the vagi are primarily motor nerves to the stomach, ulcer pain is relieved following operation. The relief is immediate and dramatic and has been noted in all cases.¹⁷ Other gastroduodenal sensations such as feelings of hunger and distention are not impaired.²⁷ Dragstedt has been able to reproduce the ulcer pain after vagotomy by instilling dilute hydrochloric acid in the stomach before the ulcer has healed.¹⁰ Ruffin, however, using the same method, has been unable to confirm his results.²⁹ This point, undoubtedly, will be clarified in the near future.

Ulcer Healing: With very few exceptions, all ulcers heal rapidly. One can only speculate as to the reasons for the failures. If the vagi are really the key to peptic ulceration, then incomplete severance of the nerves is the cause of the failure. In fact, a few of these cases were re-explored and upon finding and cutting a missed branch, the ulcer did heal. One such case of Dragstedt's had a negative insulin test despite the persistence of vagal fibers.

Ulcer Recurrence: The question of recurrences can not be factually answered at this point. As time passes, our follow-up period grows longer and more substantial. Some of the cases have now gone over three years without recurrence, which is certainly a longer interval than the unoperated usually enjoy. With the loss of ulcer pain following vagotomy, the possibility of painless recurrence with bleeding or perforation must be considered. Coming without warning, these could be very serious potential sequelae. Dragstedt, however, reporting on his 214 cases up to April of this year, had only one episode of hemorrhage after vagotomy, whereas 40 per cent of his patients gave a history of bleeding at one time or another prior to the operation.¹⁰ It is also of interest that although stomal ulcer usually develops within a year after operation, none have appeared following gastro-enterostomy or subtotal gastrectomy plus vagotomy. We are still in no position, however, to pronounce a cure, nor will we be for some years to come.

The few opportunities that have been afforded to re-examine the operative site at a later date have demonstrated that the nerves do not regenerate.

Psychosomatic: Wolf, who has extensively studied the objective changes in the stomach produced by emotional stimuli, reports the loss of these changes following vagotomy.³⁰ Moore

has noted that many of his patients no longer experienced the upper abdominal tightening and tenseness that they had had in response to situational problems before their vagi were resected.³¹ Here one might well pause again for speculation. If excessive emotional and situational tension "escapes" over vagal pathways, what new channels and forms of expression will it find after the vagi are blocked? Will vagotomy cure peptic ulcer and "belly consciousness" only to create cardiac neuroses, asthenias, and other psychosomatic manifestations? The answers to such questions must await the passage of time.

Effect on Other Organs: In view of the widespread distribution of vagus fibers to the abdominal organs, cutting the nerves should cause many alterations in the physiology of digestion. So far, no drastic changes have been noted. Biliary and pancreatic function have been unaltered following vagotomy. Blood sugar curves are apparently unaffected although the vagi are purported to be a major link in the control mechanism chain.¹⁰

Diarrhea has been noted in as high as 20 per cent of cases.²¹ Some of it may be due to the achlorhydria caused by vagotomy. For the most part, the diarrhea has been transient, disappearing by the third month, and has not been severe enough to pose a particularly serious problem.

Mild, transient dysphagia has developed in a few cases and is most probably due to the manipulation of the esophagus during the operation.²¹

The sympathetic and parasympathetic nervous systems balance each other functionally. Following sympathectomy for malignant hypertension, a latent ulcer may light up.^{25, 32, 33} If the reverse is true, vagotomy for peptic ulcer may allow the sympathetics free rein to produce hypertension. Although no extensive surveys have been made, elevation of blood pressure has not been reported after vagotomy.

COMMENT

We are in the midst of a controversy over a new method in medicine. The investigation is still in its infancy and the figures, comparisons, and criteria are just evolving. A few concepts, however, are beginning to crystallize.

Vagotomy is the most physiologic of the surgical measures available for the treatment of peptic ulcer and gives promise of being the most effective and least hazardous. At this time, it can only be recommended in the management of those cases with surgical complications and intractability to medical methods.

Although the procedure of choice must vary with the individual problem at hand, the following generalizations may be made. Subtotal gastrectomy is so effective in the management of gastric

ulcer that the addition of vagotomy seems hardly necessary. Resection of the stomach eliminates the possibility of malignant degeneration and is preferable to gastro-enterostomy plus vagotomy. In duodenal ulcer, the operation of choice is bilateral transabdominal vagotomy combined with a posterior gastro-enterostomy. This procedure is simple and safe in the hands of any competent surgeon. The vagotomy, if complete, will heal the ulcer and the anastomosis will abort the development of serious delayed emptying and retention. Stomal ulcer responds well to vagotomy alone, either transthoracic or transabdominal.

It may well be added that vagotomy should not be attempted in the presence of frank psychoneurosis. The results in these cases have been poor.³¹

In a chronic disease like peptic ulcer, no final answer may be essayed for any form of therapy without a suitable test of time. However, vagotomy has proved itself worthy of further clinical trial and bids fair to become our most effective weapon.

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Can We Retrieve Breast Feeding?

The cost of artificial feeding presents interesting economic implications. To feed a normal infant artificially for the first six months costs from \$25 to \$50, depending on the type of food used. This estimate does not include the cost of equipment or the time and effort expended in the preparation of the formulas. If one half of the babies born in Pennsylvania in the month of September, 1946, (a very conservative estimate) were fed artificially for the first six months, the cost would have been from one quarter to a half million dollars. If that amount is multiplied by the twelve months in the year and again by the 48 states, the amount reaches astronomical proportions and it becomes clearly evident that commercial enterprises competing for this rich plum will go to extraordinary lengths to secure it. Vast advertising programs, lavish entertainment at medical conventions, generous grants for research and study in various phases of infant welfare and public health projects, and a veritable pleonasm of extravagant claims calculated to disorient and confuse physicians and the public into acceptance and approval of the special brand of infant food sponsored by the commercial enterprise interested—all become "grist to the mill" if the unwary doctor and his patient are converted to the belief that the product represents the only true substitute for nature's own food—breast milk, of which "poor baby" has been so unfortunately deprived.—Norman M. Macneill, M.D., Philadelphia. *The Penna. Medical Jr.*, Vol. 51, No. 2, November, 1947.

The Complications of Electric Shock Therapy With a Case Study

DAVID W. SPRAGUE, M.D., and RICHARD C. TAYLOR, M.D.

THE rapid acceptance of electric shock therapy combined with pleasingly low number of complications has left many members of the medical profession with the idea that there are few if any troubles consequent to this therapy. There is no doubt that as a replacement for the more difficult Metrazol convulsive therapy, electric shock has become a convenient and relatively problem-free form of therapy. Even after seven years' experience with the procedure there is little exact information as to the mechanism that exists or as to just what the effect of this therapy is on the central nervous system.

From time to time an occasional difficulty in terms of a complication of an untoward effect has been reported and these have been studied in the clinical approach and by the use of laboratory investigation. Thus it is the purpose of this paper to attempt to present briefly the present knowledge of this subject and to correlate the two approaches.

COMPLICATIONS

In general, complications of electric shock therapy can be listed under the following categories: (1) Fractures and dislocations; (2) respiratory; (3) cardiovascular; and (4) neurological.

The problem of fractures and dislocations are so fewer in electric shock than in Metrazol convulsions that many workers in the field ignore them completely. Early reports by Smith¹ and others pointed to a reduction to one quarter of the frequencies experienced with Metrazol. Kolb and Vogel² report similar figures. However it is our belief that this figure has been substantially reduced to much lower percentages. During the past year at Hoover Pavillion we have given more than four thousand individual shock treatments with only two compression fractures of the vertebrae resulting. Kalinowsky and Hoch³ report that fracture of the acetabulum is frequently seen in older patients during electric shock therapy. Perhaps we have not seen this complication because of more rigid selection of patients and the ruling out of many of those older people who are in relatively poor physical condition. In sum and substance the problem of fractures revolves around the prevention of the vertebral compression fracture and the usual

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technique is to be certain the treatment is given with vertebral column in extension.

Dislocation of the jaw is not an uncommon occurrence. However, there are no reports of its statistical frequency in the literature. The reason for this is probably because any well-trained shock team automatically expects and treats this problem as it occurs. Briefly this is prevented by strongly counteracting the opening of the mouth at the beginning of convulsion and if it still occurs, reduction is accomplished immediately during the later stages of the treatment.

Occasional complaints of backache or pain in other parts of the muscular system probably represent myositis, bursitis, or even possibly small hematomas. We can only agree with Kalinowsky³ that the difficulties of diagnosis of these conditions make their analysis and reporting rare but suffice to say that their incidence has been small enough to allow them little attention.

The largest respiratory complications are to be found in the prevention and treatment of apneic phases that occasionally follow the convulsions. Any delay in the re-establishment of respiration should be immediately treated by artificial respiration and the determination that adequate air passage exists. Sensory stimuli such as slapping the face or dilation of the anal ring are definitely of value and occasionally chemical stimuli must be used. Only very rare reports of exacerbation of pulmonary disease by electric shock are found, and the attitude at present toward agitated patients with tuberculosis is that the danger of further activating the dis-

Presented before the Section on Nervous and Mental Diseases at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947.

ease by treatment is not as great as the danger that the mental condition itself may impose.

The few cases of cardiovascular disease that have been reported can all be dismissed as unhappy coincidences. There are cases reported in which there have been collapse and death shortly after the convulsion. However without exception these cases have been those who have chronic endocarditis and myocardial disease. The studies by Jetter⁴ would indicate there are two possible mechanisms for this fatal circulatory collapse. "In the first, the acute cardiac dilatation and failure are caused by the tremendous muscular exertion of the convulsion. The likelihood of such an occurrence undoubtedly bears a direct relation to the severity of already existing heart disease. In the second type of the circulatory failure, collapse may occur without recognizable heart disease, and possible results from electrical stimulation of hyperexcitable central cardioregulatory or vasomotor center. The existence of this mechanism should be regarded as hypothetic rather than proof." Thus electric shock therapy to either those people who have heart disease or those suspected of unusual lability of the central vasomotor or central cardiac neural centers should not be administered without full realization of the hazards involved.

THE EFFECTS

The most fascinating part of the study of electric shock is that of its effect on the central nervous system and the pathologies that can be ascribed to the therapy. We shall attempt to study this problem from the beginnings made by both those who studied the effects of accidental intentional electrocution and by the more recent laboratory studies in giving comparable doses of electric shock to various animals.

For several years there has been much discussion about the mode of transmission of electricity through body tissue. Hassin⁵ supplemented by Karnosh, Kawamura, and Jellinek feels that the main route of electrical transmission and the subsequent damage are along the large nerve trunks and the blood vessels. On the other hand, Alexander⁶ states his feeling that electricity passes through the body as if it were a structureless gel and supports his statements with experimental evidence and clinical cases. By and large there does not seem to be as much disagreement about the actual effect of electrical current. Hassin speaks of swelling of the ganglion cells, satellitosis, tearing of the blood vessels and of the brain tissue. Alexander⁷ gives the following description: "The general autopsy findings in cases in which the current has passed through the trunk including the heart, and where death occurred in the acute

stage following the injury, include edema of the lungs and passive congestion of spleen, adrenals, and kidneys. The brain shows edema with flattening of the convolutions, narrowing of sulci, and swelling of the central convolutional white matter; venous congestion and formation of early red thrombi in cerebral venules, small perivascular hemorrhages by diapedesis, and perivascular lesions of demyelination and incomplete necrosis which in their distribution and morphology resemble those of an acute disseminated encephalomyelitis."

One of the thought-stimulating works in recent years has been reported by Echlin⁸ who in investigation of various animals has been able to demonstrate that "arteries, arterioles and capillaries constricted promptly on electrical stimulation". While there seems to have been differences in the reaction of various species to this electric stimulation, most workers have found little to quarrel with Echlin's observation.

ON THE HUMAN BRAIN

There has developed a most heated discussion in the literature about the effects of electric shock in the human brain. Beginning with the reports of Alpers and Hughes⁹ and their fourteen cats, electric shock was supposed to create petechial hemorrhages in the path of the electric current. They also report that they believe that their two autopsies after incidental death following shock therapy tends to confirm this impression. However, there have been several papers which have taken issue with this view the most recent being that of Windle, Krieg, and Arieff¹⁰ who feel that there are no demonstrable changes in the brain following shock therapy. Ferraro has made a recent study in which he has attempted to analyze the reasons for such contradictory finds, and lists the following:

1. Intensity of electricity used for induction of convulsions.
2. Flow duration of the convulsive doses of current.
3. Size of electrode.
4. Frequency of induction of convulsive seizures.
5. Total number of induced convulsions.
6. Selection of experimental animals.
7. The careful supervision of the diet of the experimental animals.

Thus it is probably true that the observers who have described lesions were describing the effects of electricity. However, it is also true that these lesions very possibly may be the results of electricity plus unmeasured variables in terms of capillary fragility, rapid pressure changes during the convulsion, and variable reactions of vasospasms and the focal ischemia that follows electric shock.

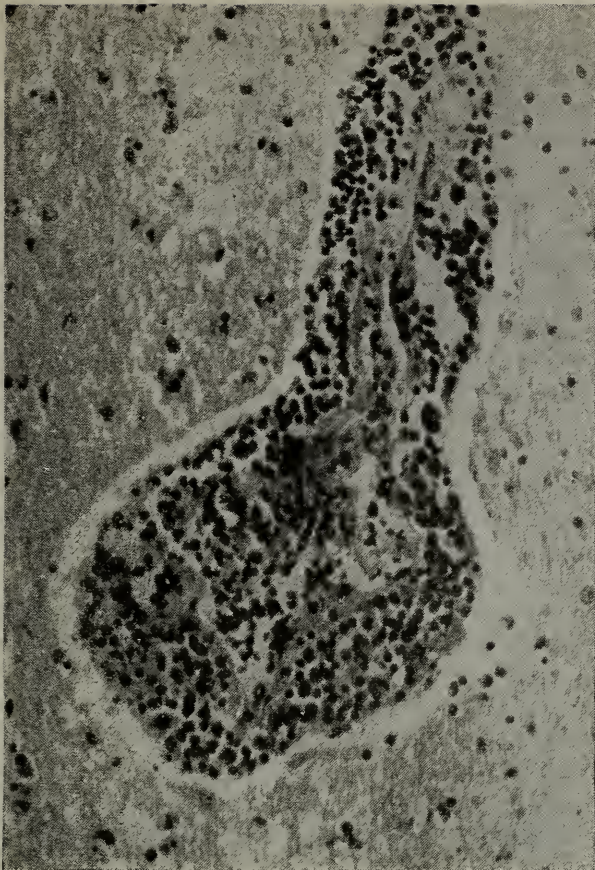


Figure 1. Showing the marked perivascular round cell infiltration seen only in the areas of the lesion.

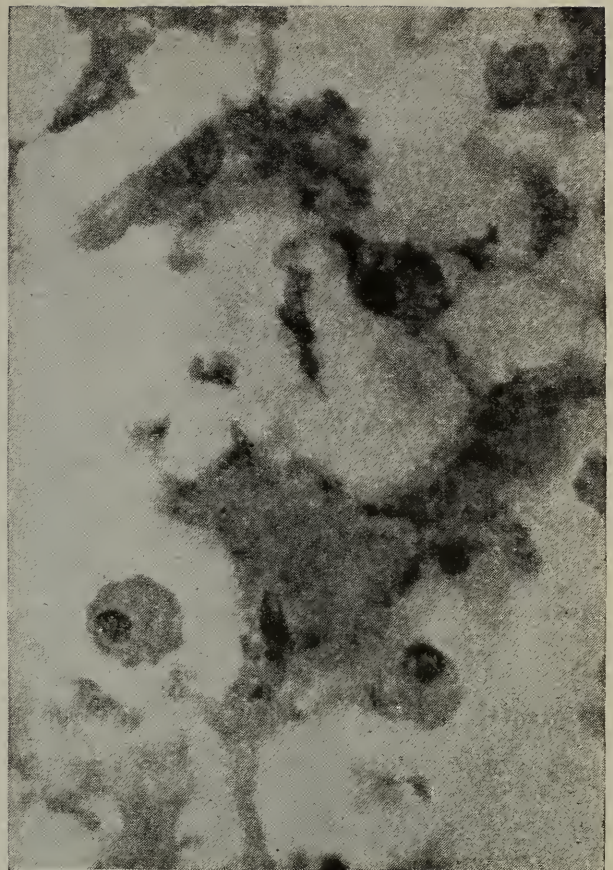


Figure 2. Higher power view showing the older Gitter cells and the hemosiderin granules that they contain.

Another thought-provoking article on the effects of electricity has been that of Ostow¹² in which he points out that in electrical terminology there is a "potential gradient" present which is of adequate strength so that areas of the brain as large as an average electrode can develop voltages as high as those used in electric shock therapy. However, since this potential is normally in equilibrium, this form of electricity likely should not play a part in the causation of the lesion unless there is a portion in the nervous tissue already damaged or diseased, and where, therefore, according to present concepts of neurophysiology abnormal discharges of electricity may be expected.

The case which has brought this question to mind is one in which there has been death following electric shock and in which a lesion has been found, the age or duration of which should correspond to the period in which electric shock was given:

CASE STUDY

M.W., a 48-year old white woman, was admitted to the neuropsychiatric in a comatose condition with the following history.

Histories obtained both at the last admission and confirmed by earlier examinations showed that this woman had shown a marked concern about her own bodily functions for the past two years. She has been visiting several physicians

for repeated examinations and requested treatment for epigastric "burning" after eating, headache, diarrhea, and questionable impairment of vision. As an example of her marked concern about herself she was scheduled for a tonsillectomy, and during the procedure, the surgeon passed a chance remark about the color of her throat resembling that of a "strep throat". This had the dual effect of convincing her that the operator did not know his business and that he had ruined her life and her throat. The affair ended with the surgeon being forced to resort to court action to collect his fee.

During the summer of 1946, she was referred to a psychiatric consultant after the above complaints were supplemented by tearfulness, depression, and periods of agitation. It soon became obvious that she was unamenable to psychotherapy so she was transferred to a private sanitarium where she was treated with occupation therapy and hydrotherapy for four weeks and was returned home showing definite improvement. Very shortly after returning home, her old symptoms returned so she was returned to the private sanitarium where she was given six shock treatments of ordinary "dosage" and discharged home, again much improved. About ten days after returning home she again became depressed, negativistic, and complained of feeling warm. Under examination at home she was at first inaccessible but later complained of feeling sick and expressed the idea that she was going to die. Over a period of forty-eight hours her condition gradually became worse and she was then admitted to City Hospital in a stuporous condition.

On examination at the hospital she showed no

significant finding except the obvious trend through lethargy, stupor, and then coma. Spinal fluid studies showed: cell count, 78 mononuclears; pandy, 4 plus; spinal fluid, protein 80 mgms. per 100 cc.; gum mastic, 3322000000. Other laboratory studies showed BUN of 27.7 and 30.1, blood sugar of 275, carbon dioxide combining power at 27 and then 48. Icteric index was 10.

Despite all efforts of supportive therapy she remained comatose and on the fourth hospital day became very dyspneic. Oxygen therapy was administered but she expired on that day.

AUTOPSY

At autopsy, examination of the brain which weighed 1300 gm., revealed a soft friable, gray mottled with purple, slightly bulging area measuring 4 cm. in maximum diameter, in the left temporal lobe and hippocampus. Two other smaller areas of similar appearance were found in the left Island of Reil and cingulum, just anterior and superior to the corpus collosum. Microscopic examination of these areas revealed necrosis, small recent perivascular hemorrhages and a slight infiltration by lymphocytes, plasma cells, and a few neutrophils. There was also some glial reaction with a beginning gitter cell formation. In the peripheral portion, there was perivascular infiltration by lymphocytes and plasma cells. These vascular cuffs were focal and confined to the above described areas. In one area, the meninges showed a similar infiltration. There was slight involvement of the left basal ganglia. In the temporal region, there was an older area of encephalomalacia with distended gitter cells some of which contained coarse granules of hemosiderin. The left middle cerebral artery contained a recent thrombus, apparently postmortem or agonal. It was not appreciably adherent but distended the artery on the left more than a somewhat similar one on the right. There was no appreciable arteriosclerosis of the arteries of the Circle of Willis. Sections of the cerebral cortex other than in the regions described, the pons, medulla, and cerebellum, were not remarkable. The dura mater and venous sinuses showed no abnormalities. Other observations were bronchopneumonia of the lower lobes; slight pulmonary edema; acute passive hyperemia of lungs, liver, and spleen, with slight central necrosis of the liver; slight, unilateral, chronic pyelonephritis; chronic cystitis; and a slight chronic periappendicitis. The uterine tubes and ovaries were not remarkable. The aorta showed only slight atheromatosis.

EXPLANATION

In attempting to explain the cerebral lesions in relation to electric shock therapy, there are lesions of two different ages. The area showing gitter cells and granules of hemosiderin in the temporal lobe is the oldest and may represent an old hemorrhagic area secondary to shock therapy. The more extensive and recent areas of necrosis, small hemorrhages, and focal encephalomeningitis are not as easily explained. They certainly do not represent the usual reaction to thrombosis or even embolism, the sources of which could only be postulated with considerable difficulty. The possibility of early brain abscess is quite unlikely as there is insufficient localiza-

tion and no satisfactorily explainable primary source. Although the clinical history contrived to suggest an involutional psychosis, one cannot be sure that the later cycles were uncomplicated. Ebaugh, et. al.,¹³ in a report of two fatalities following electric shock therapy, mentioned a very slight round cell infiltration about a small number of vessels in the globus pallidus. Ostow¹² in his article on electricity as a pathogenic agent in the central nervous system suggests the possibility of reactivation due to electric shock therapy, of previous existing lesions, among them being encephalitis.

SUMMARY

The problem of the exact effect of electric shock therapy seems far from solved at the present time. This case has been presented as another facet of evidence in the attempt to better understand the processes involved. The idea that electricity in therapeutic forms may activate another lesion or may be potentially able to create such a lesion is still unproven but this situation may lend some reason for further experimental investigation.

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Use of the X-Ray

Although the X-ray apparatus detects pulmonary lesions more readily than the stethoscope, chest roentgenology has not yet advanced to the point where it can be substituted for logic or reasoning. Diagnosis is a function of logic, and the diagnosis of chest diseases, especially tuberculosis, depends on the correlation of clinical, roentgenologic and bacteriologic studies. No X-ray machine can do this. "Never put your complete trust in shadows" is a sound medical adage that applies especially to tuberculosis.—J. D. Wassersug, M.D., *N. E. Jour. Med.*, July 13, 1947.

Clinical Variations of Primary Syphilis

IRVING L. SCHONBERG, M. D.

THE recognition of primary syphilis by inspection alone is always a hazardous procedure. Laboratory aids are always utilized to confirm the diagnosis. However, some syphilitic lesions remain undiagnosed due to the fact that "Hunterian chancre" is still used as a basis for clinical evaluation and seemingly insignificant lesions are dismissed as non syphilitic. The variability in immunity reactions as well as the site of inoculation frequently alters the clinical appearance of the primary lesion so that final diagnosis must be based upon a healing chancre and a positive serologic test for syphilis. Much valuable time is lost in initiating therapy and the unaware patient not only decreases his chances for a good therapeutic result but also transmits the infection to others.

The purpose of this paper is to point out clinical variations in primary syphilis based upon a study of almost 300 primary lesions seen in a large Army hospital.

Duration: Due to the fact that physical inspections of troops are made monthly, it is rare for lesions to be seen that are over 30 days old. The soldier now realizes that if he reports his penile lesion, the condition will be considered in the line of duty. Most cases were seen within a period of ten days following the appearance of the sore. Some had been self-medicated but in most cases lesions were untreated.

Location: With the exception of seven cases the chancre was located on the penis. The extragenital lesions included three of the lip, one on the tongue, one on the buccal mucosa, one on the finger, and one on the suprapubic area.

Intraurethral chancres were not seen but several cases treated for gonorrhea eventually developed positive serologic tests for syphilis on follow-up.

The commonest site was the frenular area on the ventral aspect of the penis. Coronal lesions predominated the entire group. Meatal lesions were infrequent.

Subjective Symptoms: Pain, both at the ulcer site and of the glands was notably absent with few exceptions.

Secondarily infected and superimposed chancreoid involvement resulted in considerable discomfort. The chancre of the tongue was accompanied by burning and tenderness. One case of chancre of the lower lip developed painful adenopathy. The chancre of the finger was attended by "throbbing pain".

Several patients complained of headache and malaise and in some there was a mild hyper-

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pyrexia. This was particularly noted in patients where diagnosis had been delayed for three or four weeks.

Clinical Types: A large number of multiple lesions of the penis were seen especially in uncircumcised negroes. Most frequently, second inoculations were present on the under surface of the foreskin in apposition to a coronal lesion.

Induration was a common attribute but in very early cases this was difficult to discern. Edema was seen frequently in older lesions.

Practically all ulcers were sharply demarcated. They varied in depth from a superficial abrasion to a deep seated, "rubbery" ulcer. In the negro, "keloid like" nodules were seen. Several presented undermining with serrated borders and were considered mixed infections.

The ulcer beds were in most cases clean and exuded a serous substance. Secondarily infected chancres were not uncommon and presented a grayish to green seropurulent exudate (see Figure 1).

The chancre of the finger (see Figure 3) presented the appearance of a paronychia and had been surgically incised on two occasions.

Adenopathy: Enlargement of glands draining the primary site was a conspicuous finding. Adenopathy was especially marked in lip and mouth lesions where enlargement caused visible deformity.

Of particular interest were the following three cases in which the diagnosis of primary syphilis was delayed due to "atypical" clinical findings.

CASE REPORTS

Case No. 1: A white soldier, 31 years of age, came to the dermatologic clinic with a yellowish crusted and exudative process involving the right leg, pubic area base of the penis and scrotum. This had been present for several weeks. He was admitted to the hospital and wet dressings

Submitted January 23, 1946.



Figure 1. Case No. 1. Chancre at base of penis.

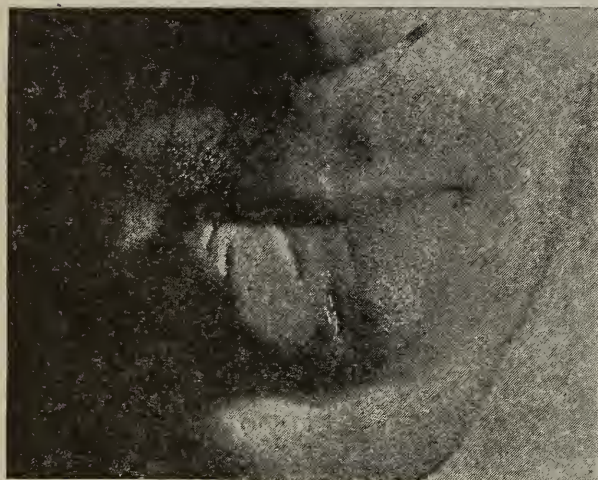


Figure 2. Case No. 2. Chancre of tongue.

of potassium permanganate and sulfadiazine ointment were applied. The leg lesion responded to therapy but on the third day edema of the penis was noted. This was accompanied by enlargement of the inguinal glands. He complained of headache and malaise. On the fourth day it was evident that an ulcer was developing at the base of the penis. Induration was progressive. Saline dressings were applied. Repeated dark-field examinations were negative.

The patient stated that he was sexually exposed four weeks previously but had used a condom.

At the base of the penis adjacent to the scrotum there was a quarter sized slightly indurated irregular ulcer bathed in a thick yellowish purulent exudate.

Serologic tests for syphilis were positive on two occasions and penicillin therapy was instituted. Twelve hours after treatment was started the penile edema and adenopathy were



Figure 3. Case No. 3. Chancre of finger.

more evident. The ulcer healed by the ninth day.

Case No. 2: A white soldier, 30 years of age, came to "sick call" complaining of a cut on the tongue which failed to heal. He had always noticed "cracks" on his tongue but one on the anterior portion had been painful.

He went on sick call and the fissure was treated with silver nitrate without results.

When seen in the dermatologic clinic he admitted exposure with a "pick-up" one month prior at which time he had placed his tongue in her mouth. He further volunteered the information that she had been hospitalized for a "venereal disease" shortly afterward.

He presented on the anterior aspect of the tongue a linear fissure surrounded by a dime sized area of induration. The submaxillary glands were enlarged. The serologic tests for syphilis were repeatedly positive. Recovery was uneventful following penicillin therapy.

Case No. 3: A white soldier, 32 years of age, was admitted to the hospital with a diagnosis of paronychia. The lesion had been incised on two previous occasions.

When first seen he presented an ulcer involving the ventral aspect of the terminal phalanx of the right index finger. The ulcer was sharply demarcated and presented a granular base. There was a moderate amount of serous exudation. The entire finger was tender and he complained of throbbing pain. The epitrochlear lymph node was enlarged. The patient stated that he worked in the paint shop and used steel wool in his work. He admitted sexual exposure four weeks prior to infection at which time he wore a condom. Infection probably occurred as a result of contact with discharge upon removing the condom.

Repeated serologic tests for syphilis were positive. Recovery was uneventful following anti-syphilitic therapy with a small amount of residual scarring.

SUMMARY

The variability of clinical findings in primary syphilis based on a study of almost 300 lesions is discussed.

Three cases are presented in which the final diagnosis of chancre was delayed due to "atypical" clinical findings.

Technique of Endotracheal Anesthesia

K. C. McCARTHY, M. D.

THE technique of endotracheal anesthesia simply consists of introducing a tube of adequate size through the larynx into the trachea with maximum ease and celerity, and with the least possible trauma to the patient. Two methods are popular, direct intubation with laryngoscopic exposure of the larynx, and the blind trans-nasal technique originated by Magill.

LARYNGOSCOPY

While this operation can be accomplished under topical analgesia it is much easier if good relaxation be produced by deep anesthesia with ether or cyclopropane. Intravenous curare is a helpful and time saving adjunct. The classical position of the patient has the head completely extended with a sand bag under the shoulders so that an extension of the straight line of the trachea passes between the teeth. A useful modification is to keep the shoulders on the table and raise the head on sand bags some six inches. This position causes less tension on neck muscles, and shortens the distance from teeth to glottis.

The most convenient laryngoscope has the battery in the handle and a lateral fenestration of the blade. Several different sizes of interchangeable blades are most desirable. It is held in the left hand and introduced from the left side of the mouth to avoid the incisor teeth which may receive additional protection by a covering of adhesive tape. The right hand moves the lips and tongue out of the way. The soft palate is seen first, next the uvula, and then the epiglottis. The beak of the instrument is then hooked over the tip of the epiglottis and pressure is exerted against the soft tissues of the tongue in a forward and upward direction. Do not use the teeth as a fulcrum, they may chip or break. The glottis is then exposed, suction may be necessary to remove mucous. The tube is well lubricated with a water soluble lubricant, then introduced in the midline with the right hand, and, choosing a time when the cords are most widely abducted, gently inserted into the larynx and about two inches down into the trachea. The respirations will be heard through the tube; a cough is common. The laryngoscope is then removed, with care that the tube stays in place. A bite block is placed between the teeth, and the distal end of the tube connected to the gas apparatus with a suitable adaptor. Packing the throat is optional, but it helps to keep the tube in place,

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prevents leakage around it and removes any danger of aspiration. The packing should be moistened with saline so that it will not abrade the mucous membrane of the mouth and throat. Finally the tube should be fixed in position with adhesive secured to the face.

Tubes for orotracheal intubation may be made semi-rigid by a coating of shellac or some similar compound or an internal metal stiffening. This makes them resistant to kinking and easier to manipulate, but increases the possibility of trauma in unskilled hands. Rubber tubes will be easier to handle if provided with an obturator, which must not quite reach the tracheal end. If the larynx is difficult to visualize, a bent obturator will help to turn the catheter "round the corner", and obviate the use of a special forceps.

We believe that petrolatum (vaseline) is inferior to water soluble, non-fatty surgical lubricant. It is apt to act as a foreign body in the bronchial tree; and obstructs the lumen of the catheter should it enter, and from whence it can not be sucked out. If it gets on the fingers it is difficult to remove and interferes with easy manipulation of the catheter. It is hard to remove the vaseline from the catheter after the operation, and it soon causes marked deterioration of the rubber.

The largest tube that will enter the larynx without difficulty should be chosen, as a better airway is thus obtained and packing is less necessary to prevent leaks or aspiration. A tube 12 mm. in outside diameter will usually fit the adult male. The following may help to correlate the varying calibration of the different catheters:

French Scale	equals	Outside Diameter Catheter in mm.	equals	Inside Diameter Magill's Tube (larger sizes) in mm.
3				

Example: 36F equals 12 mm. tube equals No. 10 Magill tube.

Read before the Section on Anesthesiology of the Ohio State Medical Association at the Annual Meeting, Cleveland, May 6-8, 1947.

Laryngoscopy is difficult in the muscular short necked individual; long maxillary teeth present further difficulty. If repeated attempts at laryngoscopy are unsuccessful the procedure should be abandoned as excess trauma may cause a severe or dangerous postoperative reaction. Good relaxation is the secret of success.

BLIND TRANS-NASAL INTUBATION

This is most easily done under light anesthesia. It is important that considerable tonus persist in the pharyngeal muscles or the tube will not be directed toward the larynx. Furthermore, vigorous breathing is very helpful in determining when the tube is near or in the larynx. We prefer, therefore, to use nitrous oxide, supplemented in some cases by minimal amounts of ether, for the hyperventilation associated with this gas simplifies the procedure. Induction having been completed and vigorous respiration established, the largest catheter that will pass easily through the most patent naris is selected. It is well lubricated and passed along the floor of the nasal passage where it is widest. When the proximal end is in the vicinity of the larynx characteristic tubular breathing will be heard through the catheter. Slight changes in the position of the head may be helpful in lining up the tube with the larynx. The "sniffing the air" position described by Magill has been found useful. When the end of the tube is over the larynx an attempt is made to introduce it when the glottis is most widely open during inspiration. If successful there is usually a characteristic cough, and tubular breathing is continued through the catheter. If the patient does not breathe through the tube, it is not in the trachea. If the tube enters easily but respiration does not continue through it, the esophagus has been entered and more extension of the head is indicated. If the tube meets an obstruction it is usually in the pyriform fossa, and the end can often be seen making pressure on the lateral neck. More flexion of the neck is indicated to direct the proximal end of the tube backward, accompanied by rotation of the tube to bring it to the midline.

If unsuccessful we should persist, reanesthetizing the patient from time to time should he show signs of recovery from the anesthesia. Often a smaller caliber catheter, or one with a different curve will be more successful. Sometimes the other naris will direct the tube more accurately. Laryngospasm may be produced by laryngeal stimulation. This is usually terminated by a vigorous gasp, during which the catheter can be inserted easily.

With a little practice it is possible to enter the trachea in over ninety per cent of cases. In those where it is impossible the anesthesia can be deepened and the glottis exposed by laryngoscopy.

This usually makes intubation easy though sometimes manipulation of the catheter through the nose will still be unsuccessful, and the tube must be grasped with Magill forceps inserted through the mouth, and introduced into the larynx. A uterine dressing forceps may be substituted in an emergency.

EXTUBATION

Extubation does not receive much attention but complications may arise upon removal of the tube. It should be left in place until reflexes have returned. All packs and sponges should be removed from the mouth or throat. The tube itself should be carefully aspirated of blood or mucous, as should the oral cavity. After removal the patient should be watched carefully for a resultant laryngospasm. This will usually terminate spontaneously, but the administration of oxygen may be required.

In our opinion the blind nasal approach has so many advantages and is so much easier and quicker that laryngoscopy is seldom used. No apparatus is required except the endotracheal tube. Deep anesthesia is not necessary, is in fact undesirable. The tube can be inserted in any position; with the patient on his side or even prone. There is no danger of traumatizing the throat, tongue, or teeth. The tube is self retaining, is not likely to kink, and can not be bitten.

Nasal intubation may cause hemorrhage from the nose occasionally; it always stops promptly. Its principal disadvantage is that the size of the tube is limited by the size of the nasal passages. It should be avoided if there is upper respiratory disease or the incidence of pulmonary complications will be doubled (Gillespie).

The principal advantage of the oral method is that a larger airway is possible. However, in most adults a 12 mm. tube can be inserted without difficulty through the nose, and will afford adequate ventilation.

To obtain the maximum advantages of the endotracheal methods we must develop our technique by constant practice until it is as simple and easy to insert an endotracheal tube as an oropharyngeal airway. In our practice it is used for all tonsillectomies, mastoidectomies, major dental extractions, and other oral, facial, and head surgery. All chest, ventral herniae, upper abdominal and kidney cases done under general anesthesia are intubated, as are any patients in a prone, lateral, or steep Trendelenburg position. Any patient that develops noticeable respiratory obstruction is immediately intubated. We find it an indispensable safeguard.

Unless we develop proficiency the method will be used only rarely, and we will be always looking for an excuse to avoid it. "Practice makes perfect."

Chronic Interstitial Pancreatitis With Diabetes Mellitus and Terminal Necrotizing Renal Papillitis

DANIEL F. RICHFIELD, M.D.

ALTHOUGH the clinico-pathologic syndrome of necrotizing renal papillitis is receiving increasing attention in the literature, this case is reported to emphasize the fact that preventive therapy is the only one likely to succeed. The onset of pyuria in a diabetic patient calls for the immediate identification of the offending organism and the strenuous application of specific chemotherapy before the onset of azotemia heralds the development of apparently irreversible and terminal changes in the kidneys.

CLINICAL ABSTRACT

E. H. A 56-year old white male was first admitted to the Cincinnati General Hospital in December of 1938 with ulceronodular gummata of the skin. He had a penile scar and a 3+ Kahn reaction, and gave a history of having had a chancre in 1923. The lesion responded to arsenical therapy. Routine urine examinations at this time were persistently positive for sugar and a glucose tolerance curve was suggestive, but not diagnostic, of diabetes mellitus. The patient was discharged to the clinic where he was followed until mid-1940. The diabetes was apparently controlled by diet alone.

The patient was next seen in the Medical Clinic in July, 1944. He complained of marked weight loss and severe diarrhea which he dated back two years to a contact with an insecticide spray. The stools, sometimes totaling 25 per day, were bulky, white, foul-smelling, and greasy. Positive physical findings included evidence of recent weight loss, a smooth, red tongue, and a palpable liver. X-ray examination detected the presence of multiple pancreatic calculi and demonstrated a normal intestinal motility with moderate puddling of barium and a serrated appearance of the jejunal mucosa.

Laboratory examination: Hemoglobin of 14.5 gms.; red blood count of 4,270,000; white blood count of 8,350; Kahn 3+; blood-urea-nitrogen 28 mgm per cent; fasting blood sugar 285 mgm per cent; serum amylase 221 units; serum calcium 9.5 mgm. per cent; urine Ph 5.5, sugar 4+, albumin negative and microscopic negative. Stool fat totaled 56 per cent. Stool cultures and blood agglutinations for the typhoid-colon bacillus group and brucellosis were negative. Gastric analysis revealed 68 degrees free acid at 30 minutes.

The patient was treated with large doses of pancreatin for his steatorrhea and of protamine zinc insulin for his diabetes. He was discharged in October, 1944, with a diagnosis of chronic interstitial pancreatitis with lithiasis, steatorrhea, and diabetes mellitus.

There were several interval admissions to the

hospital; one in late October of 1944 because of right upper quadrant pain. Oral and intravenous cholecystograms at this time revealed a non-visualizing gallbladder. No specific therapy was attempted. He continued to have many bulky, foul-smelling, greasy stools daily. In August of 1946, a cataract was extracted from the right eye. In October of the same year he was given a trial of folic acid therapy because of numbness and tingling in the extremities. The therapy was of little help and was shortly discontinued.

The patient entered the hospital for the last time in March, 1947, complaining of sharp right upper quadrant pain and dysuria associated with pain in the flanks. Physical examination revealed marked emaciation, a red, smooth tongue, a liver palpable 4 f.b. below the right costal margin and moderate palmar erythema. Position, vibratory and pain sense as well as the deep reflexes were diminished in the lower extremities. **Laboratory examination** revealed Kahn negative; hemoglobin 12 gm.; red blood count 4.55 million; white blood count 14,050 with 80 per cent polymorphonuclear leukocytes. Fasting blood sugar was 200 mgm. per cent; carbon dioxide 40 vol. per cent. Blood-urea-nitrogen 23 mgm. per cent; chlorides 500 mgm. per cent; serum amylase 163 units; serum bilirubin 0.15 mgm. per cent in one minute, 0.6 mgm. per cent total; thymol turbidity one unit; cephalin flocculation 2+ in twenty-four hours, and 3+ in forty-eight hours; bromsulfalein (5 mgm/K) 64 per cent retention; serum protein 5.29 gm. per cent; serum calcium 8.9 mgm. per cent; serum phosphorus 4.9 mgm. per cent; prothrombin time fifteen seconds compared to a standard of fourteen seconds. In the gastric juice 59 degrees of free acid were found in a thirty-minute specimen. The urine was Ph 5, albumin 2+, sugar 4+, acetone negative. Microscopic examination revealed innumerable clumps of white blood cells. Urine prophyrin studies were negative.

Because of the pyuria and the persistent low-grade fever, sulfadiazine therapy was started on the 18th of March, 1947. This treatment was ineffective. A gram-negative bacillus identified as *Shigella Alkalescens* was cultured from the urine on March 25, 1947. At this time it was discovered that the blood-urea-nitrogen had risen to 95 mgm. per cent and because of the azotemia, sulfadiazine therapy was stopped and contemplated streptomycin therapy was postponed. On the 4th and 5th of April the patient had successive attacks of dyspnea and cyanosis associated with tachycardia and transitory rise in blood pressure. The patient died shortly after the onset of the second attack.

PATHOLOGICAL FINDINGS

The necropsy was limited to an abdominal incision. The body, measuring 158 cm. in length, was that of a markedly emaciated, white male,

Submitted August 11, 1947.

appearing the stated age of 56 years. Superficial examination was unrevealing except for the coloboma of the right iris.

The pancreas was markedly firm and was approximately one half its normal size. The ducts were dilated and were filled with multiple fine, white, gritty calculi. The pancreatic parenchyma was almost completely replaced by dense bands of white, fibrous tissue.

The liver weighed 1535 gms. It was coarsely nodular and relatively firm. The gastro-enteric tract was unremarkable except for moderate diffuse hyperemia of the mucosa.

The kidneys were of equal size and together weighed 500 gms. The capsules stripped easily to reveal edematous, beefy, hyperemic cortical surfaces. Hemisection of the kidney revealed central foci of yellow-white necrosis in each renal papilla. The necrotic area was bordered by a thin, gray-green zone and circumscribed by a peripheral zone of hyperemia. In addition there were prominent medullo-cortical streaking and multiple small, white-yellow nodules in the cortex. The mucosal surfaces of the ureters and urinary bladder were red, edematous and granular.

The lungs weighed 1260 gms. and 735 gms., right and left respectively. The ramifications of the bronchial tree were markedly dilated and filled with thick, purulent exudate. There was moderate, predominantly peribronchial, pulmonary consolidation. The remaining viscera, including the heart, were not remarkable.

On microscopic examination the pancreatic substance was seen to be almost completely replaced by cicatrix in which there remained little evidence of chronic inflammatory reaction. The islets of Langerhans were diminished in number and those present, for the most part, were completely replaced by fibrous tissue. The liver presented a picture of a moderate, though active, portal cirrhosis. The bronchi were dilated and ulcerated. Their lumens and adjacent alveoli were filled with muco-purulent exudate. In the kidneys the renal papillae presented a central zone of coagulative necrosis in which a slight inflammatory reaction was evident. The tubules and interstitial tissue immediately adjacent to the zone of necrosis were filled with a purulent exudate and colonies of bacteria in enormous numbers. Gram stains revealed both gram-negative bacilli and gram-positive cocci in approximately equal proportions. Just peripheral to the zone of bacteria was a zone of hemorrhage demarcating the papillary lesion from the remaining underlying pyelonephritis. The mucosa of the urinary bladder was the seat of an active chronic type of inflammatory reaction.

ANATOMICAL DIAGNOSES

I. Acute and chronic pyelonephritis with necrotizing renal papillitis. II. Active chronic cystitis, moderate acute and chronic prostatitis. III. Acute suppurative bronchiectasis with acute fibrinous pleuritis and acute lobular pneumonia, early abscess formation (aspiration), pulmonary edema. IV. Evidence of pancreatic duct obstruction (calculi) with marked chronic interstitial pancreatitis, pancreatic acinar atrophy, marked interstitial fibrosis and moderate fibrosis of the remaining islets of Langerhans. V. Active moderate portal cirrhosis of the liver, chronic

passive congestion of the spleen and gastro-enteric tract.

COMMENT

Necrotizing renal papillitis is not an uncommon lesion. In the series of Edmondson, et al.,¹ the lesion was observed in 29 of 859 diabetic subjects representing an incidence of 3.4 per cent in diabetics. In the series of Robbins, Mallory, and Kinney² the incidence of necrotizing renal papillitis in diabetic patients was 4.5 per cent. This is not an inconsiderable figure when it is realized that it represents approximately 25 per cent of all diabetic patients that develop pyelonephritis.

Clinically the lesion may run a fulminating or a subacute course. This case is an example of the latter type, in which a period of pyuria with obvious pyelonephritis for several weeks was followed by a sudden severe exacerbation which progressed rapidly to a fatal termination. It should be emphasized that the degree of severity of the diabetes does not appear to be a factor in the pathogenesis of the lesion.

It is also of interest in this case that despite the prolonged history of enteric tract dysfunction associated with the pancreatitis there was no demonstrable histologic evidence of gastro-enteric disease.

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Mental Health

Human machinery is so complex in its various operations that every one of us, otherwise sound, experiences now and then some indication of a functional disorder; either there is a gastric manifestation, or a vague pain, or a cardiac palpitation or a fugacious neuralgic discomfort. But being normally constituted, we give all such symptoms their proper interpretation, our attention is not firmly arrested on them, we continue our activities in spite of them. Furthermore, we are able to overcome unpleasant circumstances which may arise at any time, we may even surmount obstacles of a most serious nature. Our relative indifference to all such conditions constitutes a normal state of mental health.—Alfred Gordon, M.D., Philadelphia Medicine, Vol. 43, No. 8, October 4, 1947.

Malignant Carcinoid of the Jejunum*

WILLIAM SINCLAIR, JR., M. D.

CASE REPORT

A 47-YEAR old negress was admitted to Lakeside Hospital for the first time on December 14, 1946, with a chief complaint of abdominal pain and vomiting of four weeks' duration.

She had been well until 14 months previously when she developed frequent episodes of hard, crampy epigastric pain following meals, associated with vomiting of undigested food and green colored and occasionally coffee ground material. Accompanying this was anorexia, slight diarrhea, and occasional tarry stools. Large masses were palpated in the lower abdomen which were considered fibromyomata. The above symptoms persisted for about ten months, during which time she lost 20 pounds. She was relatively symptom free for three months. Four weeks prior to admission she developed similar episodes of epigastric pain, vomiting, anorexia, and diarrhea which became progressively more frequent and severe.

On admission the patient was well developed and nourished and did not appear acutely or chronically ill. The temperature was 37.7°C, pulse rate 75, respiratory rate 20, and blood pressure 150/70. General physical examination was not remarkable except for a large nodular uterus which extended nearly to the umbilicus and a rectal polyp which later proved microscopically to be benign. Urinalysis was normal. The red blood count was 3.25 million, hemoglobin 35 per cent, white blood count 5,000 with normal differential count. Blood Kline was negative. Blood urea nitrogen was 6.8 mg. per 100 cc. Serum chlorides 105.2 m. eq. per liter. Serum protein 6.1 mg. per 100 cc. Feces were benzidine positive. Pin worm ova were present in the stool on one occasion.

Roentgen examination of the small intestine revealed a dilated gas containing loop of middle or distal jejunum. A point of narrowing was noted distal to this which measured approximately 6 cm. in length and appeared to be kinked. Passage of barium was delayed eight hours, but the cause of this partial obstruction could not be determined.

On February 24, 1947, an exploratory laparotomy was performed. A jejunal intussusception 30 cm. long was easily reduced. The adjacent mesenteric root contained three lymph nodes. Immediate frozen section of one node showed carcinoid tumor. The involved segment of jejunum and mesenteric root was resected and a panhysterectomy performed. Postoperatively the patient received intravenous fluids, blood transfusions, penicillin, and vitamins. Constant Wangenstein suction was maintained. On the twelfth postoperative day a loop of bowel was accidentally perforated when a trocar was inserted because of suspected accumulation of fluid. The perforation was closed under local anesthesia. The patient continued to have low

grade fever and abdominal tenderness. Peristaltic sounds were not heard. Death occurred suddenly on the eighteenth postoperative day, 90 days after admission.

SURGICAL SPECIMEN

The segment of jejunum measured 22 cm. in length and had an average circumference of 7 cm. The mucosal surface, on the anti-mesenteric border, presented two, transversely located, ulcerated, yellow tumor masses. The larger measured 2.5 x 2 x 1 cm., was well defined and projected into the lumen a distance of 0.8 cm. The surface was finely granular, ulcerated, and somewhat lobulated. Transections revealed a well-defined tumor which replaced the mucosa and submucosa and portions of the muscularis and extended nearly to the overlying retracted serosa.

The smaller tumor, located 9 cm. distally, had a similar appearance, measured 1.2 x 1 x 0.8 cm. and projected into the lumen 0.6 cm. The surface was umbilicated and ulcerated. On transection the tumor was confined to the mucosa and submucosa. The overlying serosa was not retracted.

The wall of the proximal portion of the bowel was uniformly thickened. The muscularis averaged 0.2 cm. in thickness. The submucosa was prominent and white and the mucosa was edematous. In the distal portion the muscularis was thinner and the submucosa was indistinct.

The surface of the root of the mesentery adjacent to the larger tumor was thickened over an area measuring 3.5 x 2 cm. by several, firm, gray, opaque plaques from which extended linear projections. Embedded in the root were three, well-defined lymph nodes, the largest of which measured 1.5 cm. in diameter and on section presented a firm, uniform, yellow cut surface. The other two nodes measured 1 cm. in diameter. Sectioned surfaces were soft, uniform and tan.

MICROSCOPIC DESCRIPTION

The tumors were composed of nests, cords, and acini of small, uniform, strikingly similar, polygonal cells which had indistinct outlines, light staining pink cytoplasm, and relatively large round nuclei containing finely dispersed chromatin. Mitoses were exceedingly rare. The nests were separated by strands of partly hyalinized connective tissue containing vascular channels. In the larger tumor, carcinoid cells had invaded the muscularis and serosa and were present in blood and lymphatic channels.

One section of what grossly was considered a lymph node in the mesentery showed similar tumor cells and connective tissue. Another section of lymph node showed atrophy, edema and a well-defined area of necrosis in which there were no identifiable cells. Argentaffin stain (Masson) of a mesenteric lymph node showed the tumor cells to have moderate affinity for silver.

AUTOPSY (9540)

There was a small, traumatic perforation of the jejunum and widespread, fibrinopurulent peritonitis from which *B. pyocyaneus* and *B. proteus*

* Selected by H. T. Karsner, M. D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals of Cleveland, as the thirty-seventh of a series of cases to be published under the heading of "Case Records Presenting Clinical Problems". Submitted July 14, 1947.

were cultured. Several lymph nodes were present in the root of the mesentery, one of which microscopically contained typical carcinoid tumor. The liver contained several, well-defined, yellow nodules measuring 0.2 to 0.3 cm. in diameter which microscopically proved to be carcinoid. There were no other metastases.

Significant pathological diagnoses were malignant carcinoid of the jejunum (surgically resected) with metastases to mesenteric lymph nodes and liver, traumatic perforation of jejunum distal to the site of anastomosis, widespread, organizing, acute, fibrinopurulent peritonitis, aneurysm of the left internal carotid artery with thrombosis, multiple recent infarcts of the left cerebral hemisphere and hypertrophy and dilatation of the heart (420 grams).

COMMENT

Carcinoid tumors have been extensively discussed by many pathologists. Forbus,¹ in 1925, published an excellent historical review. The word carcinoid was coined in 1907 by Oberndorfer² who stressed the benign nature and sought thus to distinguish the lesion from true carcinoma. Numerous theories of origin have been formulated. The majority of writers agree that carcinoids arise from argentaffin cells of the crypts of Lieberkuhn as proposed by Masson.³

These tumors occur infrequently. Ritchie and Stafford⁴ stated that 321 cases had been reported up to 1944. They are most frequently found in the appendix. They are found in all portions of the gastro-intestinal tract and have been reported in ovarian teratomas.⁵ The terminal ileum is the most common site in the small intestine.

Carcinoid tumors of the small intestine have been adequately reviewed by Cooke⁶ in 1930, Ariel⁷ in 1939, and Dangremond⁸ in 1942. Of the total of 283 cases reviewed by these authors, 28 (10 per cent) occurred in the jejunum. Of these, 7 (25 per cent) produced metastases. Symptoms of intestinal obstruction occurred in only 2 of the 14 cases reviewed by Ariel⁷ and Dangremond.⁸ The remainder were incidental observations at autopsy.

The diagnosis of carcinoid tumors of the small intestine preoperatively is exceedingly difficult and rarely made. Symptoms have occurred in approximately 25 per cent of the reported cases. Typically there is long standing progressive partial intestinal obstruction. Melena is not characteristic as these tumors are not often ulcerated. This is in contrast to adenocarcinoma which generally erodes the mucosa. Miller and Herrmann⁹ in 1942 pointed out that the presence of kinking and tumor at the site of obstruction may be a helpful roentgen sign of malignant change. Malignant carcinoids characteristically infiltrate through the wall of the bowel and involve the serosa and adjacent mesenteric root. This results in constriction and shortening which produces kinking and knuckling of the bowel.

The intraluminal growth may be slight. Botsford and Seibel¹⁰ did not find a single report in the literature or in their own records of small, benign, nodular, submucosal carcinoids producing roentgen signs of smooth, dome-shaped or polypoid filling defects projecting into the lumen. Other small intestinal tumors, however, such as lipoma, polyp, leiomyoma and carcinoma tend to grow into the lumen and thus produce intussusception and obstruction. Keifer and Lahey¹¹ stated that 30 per cent of all tumors of the jejunum and ileum produce intussusception.

Watz¹² reported intussusception and obstruction occurring in the jejunum and ileum in a patient who had multiple carcinoid tumors which produced widespread metastases.

The earlier authors generally considered carcinoids benign. There is no doubt today, however, that these tumors may often be malignant and furthermore that the incidence of malignant growth varies with the site of origin. Bonar¹³ states that it is generally agreed that carcinoids of the appendix are benign. Potter and Doctor¹⁴ reported the fifth case of carcinoid arising in the cecum. All five cases had local and distant metastases. In the jejunum, metastases have occurred in about 25 per cent of reported cases and in the ileum in approximately 35 per cent. Cooke⁶ in 1930 reported an incidence of 20 per cent malignant growth and Ritchie and Stafford⁴ reported metastases in 123 of 321 published cases, an incidence of 38.3 per cent. This apparent increase may be partly due to the reporting mostly of those cases which metastasized and thus aroused interest.

Dockerty and Ashburn¹⁵ "contend that all carcinoid tumors are malignant neoplasms arising from glandular epithelium and therefore carcinomas in every sense of the word", and should be classified as grade I adenocarcinoma (carcinoid). In their series carcinoids thus comprised 23 per cent of all malignant neoplasms of the small bowel. Karsner,¹⁶ however, considers carcinoids essentially hamartomas. Some become neoplastic and metastasize. Microscopically it is impossible to tell benign from malignant unless there is invasion or metastases.

Treatment consists of resection of the involved segment of intestine and mesenteric root. Resection in cases with metastasis has been advocated by Horsley.¹⁷ These tumors progress slowly. Cameron¹⁸ reported a patient who was alive and well eight years after resection for malignant carcinoid of the ileum which had metastasized to the mesentery. Mallory¹⁹ recorded a case of carcinoid of the ileum with regional lymph node metastases in which the patient lived 20 years after resection of a segment of ileum. At autopsy the metastases were still present but the tumor had not spread elsewhere. Terplan, Weintraub and Wolf²⁰ reported a pa-

tient who lived five and one-half years after ileocolostomy for carcinoid tumor with hepatic metastases. Death occurred by accidental drowning and at autopsy the metastases had not significantly enlarged. Roentgen therapy has been suggested but not used in a sufficient number of cases to permit conclusions.

SUMMARY

A case of multiple (2) malignant carcinoid of the jejunum occurring in a 47-year old negress which produced partial intestinal obstruction, intussusception, and metastases to the mesenteric lymph nodes and liver is reported.

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The Psychoneurotic

There are observations sufficiently illustrative to contend that the real cause of psychoneurotic phenomena does not lie in accidental occurrences, such as traumatism, fatigue or local disease, etc. These factors react on us all daily, hourly, and do not produce disorders of a permanent nature. A psychoneurotic individual on the contrary reacts differently because of the special make-up of his special mental characteristics.—Alfred Gordon, M.D., *Philadelphia Medicine*, Vol. 43, No. 8, October 4, 1947.

KEEPING UP WITH MEDICINE

● THE syndrome of "iodism" consists of nasal catarrh and gastro-intestinal disturbances including a brassy taste in the mouth, anorexia, nausea, vomiting, intestinal cramps and diarrhea—also various skin eruptions including iodine acne, erythema multiforme, angio-neurotic edema, fungous and vegetative eruptions, and exfoliative dermatitis similar to that produced by arsphenamine.

* * *

● WHAT students of rural health sometimes overlook is that we have an urbanized rural society.

* * *

● THE CHANCE of an infant being essentially a perfect specimen and showing robust health are four times greater when the mother's diet has been superior.

* * *

● How large a dependence upon grain products in the human dietary consistent with optimal nutrition will depend very largely upon what amounts of other food crops are raised and used.

* * *

● ILLNESS does not transform a human being into something. He remains as much of a person as his healthy brother.

* * *

● HIPPOCRATES observed "the physician only applies the splint, nature heals the broken bone".

* * *

● THE physician is always faced with the possibility of appendicitis during a pregnancy.

* * *

● THE use of penicillin and other antibiotics as aerosols for the treatment of certain pulmonary infections is a logical procedure. Theoretically, it should also be a good way to treat an allergy of the bronchi (asthma) with this drug.

* * *

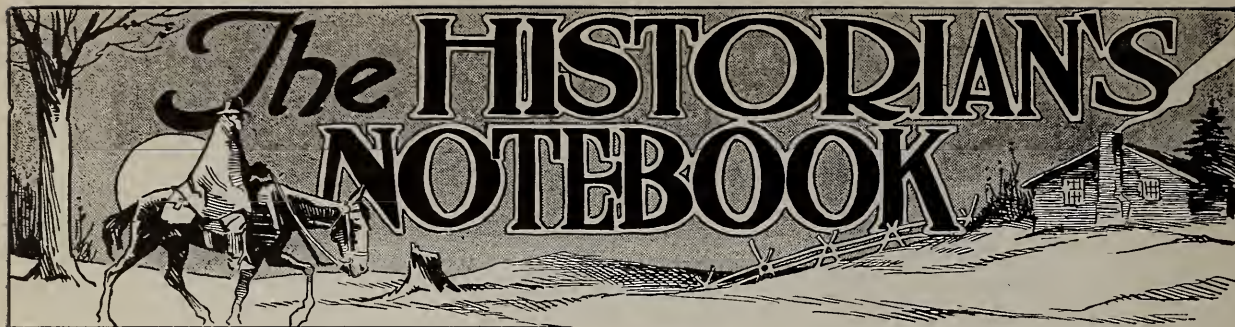
● THEY are now using early ambulation of patients after cataract operations.

* * *

● BIOTIN is widely distributed in the natural foods, being especially prevalent in liver, molasses, and milk, but in fair quantity in meats and most vegetables that have been assayed. So it seems doubtful whether any but the most extreme dietary regimen would result in a dietary deficiency in man.

* * *

● THE two commonest conditions which must be differentiated from thrombosis of the cavernous sinus are orbital cellulitis and lateral sinus thrombosis.—J.F.



The History of Medicine in Summit County— A Book Review

JONATHAN FORMAN, M.D.

AS our culture here in Ohio suffers the inevitable changes associated with the increment of time, more of our physicians become interested in the history of their profession, of their community, and in the integration of the two. As one result of this, there have appeared in the last 15 years, more than 300 articles on the local medical history of Ohio by these physicians. Outstanding among these amateur historians is Alexander Stearns McCormick, M.D., F.I.C.A., of Akron, who has done an outstanding job by specializing on his home county (*The History of Medicine in Summit County, Ohio*. \$2.50. The Hobson Book Press, 52 Vanderbilt Press, New York 17, New York). This volume represents almost a continuous effort on the part of the author and some of his associates for the past 35 years and more, for Dr. McCormick's first article on the subject appeared in the *Akron Beacon-Journal* on November 8, 1912. Summit County was also fortunate in that its "County Histories" of 1854, 1881, 1892, 1898, 1908, and 1918 all contained more than the usual amount of biographical data on the local physicians, past and present, and these made an excellent foundation on which to build. "Since then, every available source of information, library and verbal, has been explored for information culminating in the present history."

The method of presentation adopted is one that makes for easy reference. Beginning with a short sketch of the Ohio country from the time of Rene Robert Cavalier, Sieur de La Salle (1643-87), to the settlement of Hudson, Ohio, in 1800 by a group of pioneers from Connecticut headed by Daniel Hudson, among whom was Dr. Mose Thompson, to the end of 1946. The main events in Akron medicine are summarized year by year.

In the second section is a list of the Officers of the Summit County Medical Society from 1842 to 1946. Next is a list of the 14 Akron

physicians who have invented or designed instruments together with descriptions of the devices. This, in turn, is followed by a short historical sketch of each of the 23 hospitals of Summit County, in service or proposed.

This volume closes with a short but discouraging look into the future, as the author faces the threat of nationalization of medicine through Federal government control.

Dr. McCormick has done the physicians of Summit County a great service in bringing together all of this source material. Such an effort must always be made first before a real history can be written. He has also done a great service to the physicians of this country in that he has shown them how the data on the history of the local profession can be assembled and preserved, before it is too late, in new volumes at the minimum of expense by the use of the very satisfactory offset process. It should inspire many another "collector" to publish and thus preserve his material.

Some day, there must come, I hope, into the midst of the Akron profession, a man who will rewrite all of this material which Dr. McCormick has so carefully assembled, and integrate it into the story of the life and development of the great city of Akron.

In writing of local history, we physicians, working as amateur historians, are inclined to emphasize the curious and neglect the routine. The professional historians then come along and use our source material to weave into their story of the time, leaving a very low impression of the knowledge of medical men at all times.

The same could have been done for the physiologist upon whom the physician has always depended or for the chemist and physicist upon whom the physiologist in turn always depends. Medicine will always be integrated into society. When we in the United States allowed our Federal government to impose graduated income

taxes and inheritance taxes, we moved away from a republic of states and towards totalitarianism. These are the first two steps toward the dictatorship proletariat as outlined by Karl Marx. As the funds from these taxes moved into the National Capital, the separate states began to give up their rights and to accept the return of some of their own tax money in trade for their own freedom and rights. Taxation for welfare takes by force from those who create wealth to give to those who cannot or do not create real wealth; and therefore, taxation for welfare purposes is not only robbery but it, too, leads inevitably to totalitarianism, since it gives a vested interest in the poor and unfortunate to the ruling class so that paupers and the sick come to be a capital asset of the government and government is no longer you and me but a small group of people who can now keep their power and live better than the rest of the country.

Dr. McCormick is to be congratulated that in making strictly a source book he escaped the pitfall of so many of us amateur medical historians of viewing the pioneer physician's methods with disdain.

In his little postscript of prophesy, he is right in fearing this advent of nationalized medicine although he fails to point out that with it will come a destruction of the states and their rights as we have known them in our republic, and a socialization of our society in which we shall all share equally in our poverty, and medicine will be no worse than our food—all will be bad—and a Dictator shall rule.

I hope every physician will get a copy of *Medicine in Summit County*, enjoy it, and begin to help collect data about medicine through the years in his own county.

Ohio Medical Society—1880

In the Fall we find the society meeting again in Lima with President Collamor in the chair. Dr. S. S. Thorn reported some surgical cases; Dr. P. H. Brooks, "Diphtheria"; Dr. Beardsley, "In What Relation Ought the Medical Profession Stand to the Laity"; Dr. J. V. Richardson presented a specimen of carcinoma of the liver. Dr. W. U. Hickey offered the following resolution, "*That this society petition the Legislature of the State of Ohio to pass a law regulating the licensing of physicians, and that a committee of two be appointed from each county in the district comprising this association to solicit the aid and influence of their respective representatives to have this law passed.*" It was carried and done.

Then Dr. S. B. Hiner read a paper on "Pyelo-Nephritis"; Dr. W. N. Nuding, "Criminal Abortions"; Dr. A. N. Small, "Epizootic".

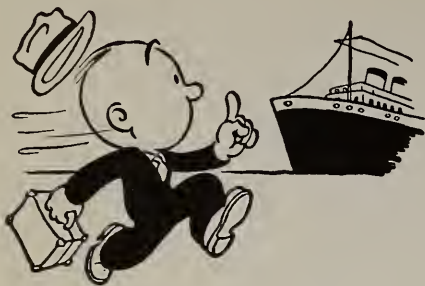
The Industrial Revolution

The industrial revolution of England strangely enough spread westward to America rather than to the continent of Europe.

In the midst of comparatively high wages and abundant employment, labor became much dissatisfied, and in some respects justly so. The work day was from 12 to 16 hours. One of the early conflicts centered about demands for a 10-hour day. In the new system the artisan had lost his old independence. He could not afford the costly machinery; therefore, he had to work for those who could provide such machinery, and had to join others in factories built around power. Labor was much concerned in the use of child labor, which left no time for schooling. Further, labor widely demanded free public schools. During this period the few public school pupils were regarded much in the same class as adults, forced into poorhouses. Better children attended private schools. Pauper children attended public schools. Labor at this time protested the endless jailing for debt. Up to 1830, about 75,000 persons yearly were jailed for debts. Labor unions had appeared before 1800. Strikes occurred in New York, Philadelphia, Boston, and Baltimore by 1807. By 1825, labor unions were so well established as to justify their own publication. The years 1825 to 1837 saw the first real rise of labor in this country. Unions by 1836 had 300,000 members.

In order that we may never overlook the actuality of manufacture in the United States in the period mentioned, let it be noted from a bewildering mass of possibilities, that axes, picks, scythes, and other edged tools along with iron stoves, were in wide manufacture. In 1831 the McCormick reaper appeared. Planing mills revolutionized the wood industry. The Colt revolver was first manufactured in 1835. Firearms and ammunition were widely demanded. The manufacture of friction matches was introduced. Illuminating gas was first manufactured for street use in New York City in 1830. The Morse telegraph was invented in 1835. During the decade beginning in 1830, railroad trackage grew to 3,000 miles.

Thus far unmentioned in this recital is the period's chief symbol—Andrew Jackson. As the seventh President, he began his two terms in 1828. All his predecessors had been of the gentry, Washington, Jefferson, Adams, Madison, Monroe and then Adams, the younger, were motivated by the concept that this country had been organized as a republic—republic in which the people shared in the government. Then along came Jackson with his slogan, "Let the people rule". Quickly the republican aristocratic concepts were thrown out of government.—Carey P. McCord, M.D., Detroit. *Industrial Medicine*, Vol. 16, No. 11, November, 1947.



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**For the 1948 Annual Meeting—Ohio State Medical Association
CINCINNATI, OHIO — MARCH 30 thru APRIL 1**

NAME AND LOCATION	Single	Double	Double Twin Beds
NETHERLAND PLAZA, Fifth and Race Sts. (Headquarters Hotel)	\$4.00-\$10.00	\$6.50-\$12.00	\$7.00-\$12.00
ALMS, McMillan and Victory Parkway			\$6.00-\$ 7.50
BROADWAY, Fourth and Broadway	\$3.00		\$5.00-\$ 6.00
FOUNTAIN SQUARE, Fifth and Vine	\$3.00-\$ 4.00	\$4.50-\$ 5.50	\$5.50-\$ 6.50
GIBSON, Fifth and Walnut	\$3.25-\$12.00	\$5.50-\$12.00	\$6.00-\$12.00
METROPOLE, 609 Walnut	\$2.50-\$ 6.00	\$4.00-\$10.00	\$5.00-\$10.00
PALACE, Sixth and Vine	\$1.75-\$ 3.00	\$3.50-\$ 4.00	\$4.50
SINTON, Fourth and Vine	\$3.00-\$ 8.00	\$5.00-\$ 8.00	\$6.00-\$10.00



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Mail the coupon to hotel selected

Manager _____ Hotel, Cincinnati, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, March 30, 31, and April 1, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____
☐ Twin Bed Room with bath ☐ Suite

Arriving _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION.

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Proceedings of The Council

Heavy Docket of Business Considered at December 14 Meeting; Policies Established on Various Questions; V.A. Fee Schedule Approved; State Association Budget for 1948 Established

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, December 14, 1947. Those present were: President Rutledge, President-Elect Brindley, Treasurer Worstell; Councilors Swartz, Messenger, Bowman, Mundy, Dixon, Davis, Lincke, Tronstein, Micklethwaite, and Clodfelter; Dr. Jonathan Forman, Editor of *The Journal*; Dr. C. C. Sherburne, Delegate to the A.M.A.; Dr. John D. Porterfield, State Director of Health; Dr. Horace B. Davidson, member of the Committee on Public Relations and Economics; and Secretaries Nelson, Saville, and Page.

The minutes of the meeting held on September 13 and 14, 1947, at Granville, were approved, on motion by Dr. Messenger, seconded by Dr. Dixon, and carried.

MEMBERSHIP DATA

Membership statistics were reported as follows: Total membership as of December 13, 1947, 7,091, of which 74 were in military service and members through waiver of dues.

The question of continuing the policy of waiving dues for physicians serving temporarily in the Armed Forces was discussed. On motion by Dr. Clodfelter, seconded by Dr. Lincke, and carried, The Council approved the waiver of State Association dues for such class of members during 1948.

Following reports by members of The Council of the activities in and visits to their respective districts, Dr. Rutledge requested members of The Council to obtain from their respective county medical societies the names of all members who have attained the age of 75, have been members of the State Association for 20 years or more, and have been practicing medicine for 50 years or more, and to report their findings to The Council at its next meeting.

NEW COUNCILOR ELECTED

A communication from Dr. Arthur J. Tronstein, Newark, Councilor of the Eighth District, tendering his resignation as Councilor in order to begin a two-year residency in dermatology at Cincinnati General Hospital, effective January 1, 1948, was read. Dr. Tronstein verbally expressed his regret at having to take this action and reported on a conference which had been held by various officers of county societies in the Eighth District with respect to his successor. The names of several members from the Eighth District suggested by the conference were con-

sidered by The Council. On motion by Dr. Dixon, seconded by Dr. Lincke, and carried, The Council accepted with sincere regret the resignation of Dr. Tronstein, expressed to him appreciation for his untiring efforts and excellent services as a member of The Council, and elected Dr. Chester P. Swett of Lancaster as Councilor of the Eighth District to serve the unexpired term of Dr. Tronstein, expiring in the Spring of 1949.

CANCER ACTIVITIES

The Executive Secretary presented for the information of The Council a report on a meeting of the Committee on Cancer of the State Association held on Saturday evening, October 25, in Columbus. On motion by Dr. Dixon, seconded by Dr. Swartz, and carried, the report and recommendations of the committee were approved. The Executive Secretary reported that to date 45 county medical societies have established cancer committees. The assistance of The Council in having cancer committees formulated in counties which have not reported was solicited.

LABORATORY APPROVAL PROBLEM

Dr. Rutledge requested Dr. John D. Porterfield, State Director of Health, to discuss the question involving the present State standards governing the approval of laboratories rendering services under the Ohio prenatal and premarital blood tests laws. Dr. Porterfield stated that at the present time the Ohio Department of Health is requiring laboratories to seek such approval to meet certain evaluation requirements, but that the department is not requiring at present that these laboratories be under medical supervision or that they employ technicians who meet certain minimum qualifications, as suggested by the Ohio State Medical Association and the Ohio Society of Clinical Pathologists. He outlined what, in his opinion, were certain difficulties in enforcing these additional requirements.

Dr. Horace B. Davidson, a member of the Committee on Public Relations of the State Association and a former officer of the Ohio Society of Clinical Pathologists, at the request of Dr. Rutledge, also discussed this question, supporting the recommendation that laboratories be required to have a medical director and be required to employ technicians who meet minimum requirements.

Following an extensive discussion, on motion by Dr. Brindley, seconded by Dr. Swartz, and

carried, the question was referred to the Judicial and Professional Relations Committee for study and a report back to The Council.

V. D. CARE OF INDIGENTS

A communication from a member, suggesting an increase in the fee schedule of the Ohio Department of Health for the treatment of venereal diseases in indigent cases, was discussed. Dr. Porterfield was requested to comment. He pointed out that there are comparatively few cases falling under this fee schedule inasmuch as the great majority of cases are being treated at local clinics and at the Rapid Treatment Center in Columbus. Members of The Council pointed out that this program has not been working satisfactorily for many reasons and that in the final analysis such cases should come under the regular indigent relief program of the local area. On motion by Dr. Lincke, seconded by Dr. Messenger, and **carried**, The Council recommended that the Ohio Department of Health abolish the present plan of paying physicians for the treatment of indigent luetics and that treatment in such cases be paid for by local relief authorities to whom drugs and sterile water for use of physicians would be furnished without cost by the Ohio Department of Health.

STERILIZATION OPERATIONS

A communication from the Ohio Department of Health, filed at the request of the Advisory Board of the Division of Child Hygiene, pointing out that there appears to be an unnecessary number of sterilization operations being performed on lying-in patients in some hospitals and raising certain questions as to the professional, moral, and legal issues involved, was read and discussed. On motion by Dr. Dixon, seconded by Dr. Tronstein, and **carried**, this question was referred to the Committee on Judicial and Professional Relations for study and a report back to The Council.

HOSPITAL BUILDING PROGRAM

Dr. Porterfield discussed, at the request of Dr. Rutledge, the status of the Ohio Hospital Survey and the Hill-Burton hospital building program in Ohio. Dr. Porterfield stated that the Hospital Advisory Council recently appointed would meet in the near future for the purpose of reviewing and acting upon the proposed Ohio plan. He said that the statistical survey had been completed and that as soon as the Ohio plan is approved by the Advisory Council and by the Surgeon General in Washington his department would be ready to pass on applications for Federal aid. Some of the details of the program relative to priorities, standards, etc., were discussed at some length. The Council was advised that among those appointed to the Hospital Advisory Council were Dr. R. L. Rutledge, Alliance,

President of the Association; Dr. George A. Woodhouse, Pleasant Hill, a member of the Committee on Public Relations and Economics of the State Association; and Mr. Charles S. Nelson, Executive Secretary of the State Association (see page 78 of this issue of *The Journal*).

1948 ANNUAL MEETING

The Executive Secretary reported on the progress being made on plans for the 1948 Annual Meeting in Cincinnati, March 30-April 1. The question of establishing dates for the Annual Meeting several years ahead was discussed. On motion by Dr. Clodfelter, seconded by Dr. Worstell, and **carried**, the Executive Secretary was instructed to tentatively engage space in Cleveland for the 1949 Annual Meeting, subject to final approval by the House of Delegates at the Cincinnati meeting in 1948.

NEW V. A. FEE SCHEDULE

A communication from the Central Office of the Veterans Administration, Washington, with respect to proposed changes in the medical and surgical fee schedule of the Ohio plan for medical care of veterans, was presented to The Council for discussion, copies having been sent to members of The Council prior to the meeting. Also discussed was a proposed new agreement between the Ohio State Medical Association and the Veterans Administration to be effective January 1, 1948. The schedule submitted to the Veterans Administration by the State Medical Association last June was accepted by the Veterans Administration with certain minor changes, most of which involved the establishment of minimum and maximum fees for certain procedures.

After a general discussion, on motion by Dr. Clodfelter, seconded by Dr. Dixon, and **carried**, The Council officially approved the fee schedule as revised and authorized the signing of the revised agreement to take effect January 1, 1948.

The President instructed the Executive Secretary to transmit information regarding the new fee schedule to members at the earliest feasible date.

REPORT ON INVESTIGATION

Dr. Swartz submitted a report on behalf of the council of the Cincinnati Academy of Medicine relative to the investigation by that body of certain charges which had been made against a Cincinnati physician in connection with the treatment of an Ohio veteran and which had resulted in the physician being removed from the list of certified physicians eligible to treat veterans under the out-patient program. This matter had been referred to the council of the Cincinnati Academy of Medicine by The Council of the State Association for review. The report pointed out that the physician had not been informed of the charges made, had not been given an opportunity to be heard by the Veterans Administration, and

that in the opinion of the Cincinnati Council there was insufficient evidence to substantiate the charges. The report recommended that the physician be reinstated on the list of certified physicians and that the Veterans Administration be requested to send a formal apology to him. On motion by Dr. Bowman, seconded by Dr. Davis, and carried, the report of the council of the Cincinnati Academy on this matter was approved and the Executive Secretary was instructed to submit a copy of the report and recommendations together with the action of The Council of the Ohio State Medical Association to the proper officials of the Veterans Administration for action.

EXTENSION OF ACTIVITIES

Dr. Dixon, chairman, submitted a report on the activities of the Committee on Extension of Activities and reported on a meeting of the committee held in Columbus on Sunday, October 26. On motion by Dr. Davis, seconded by Dr. Lincke, and carried, the report of the committee and its recommendations were approved. Dr. Dixon suggested to President Rutledge that the Committee on Extension of Activities, which was a special committee, be dissolved and that in the future matters which had been considered by that committee be referred to the Committee on Public Relations and Economics.

LOCAL OFFICERS' CONFERENCE

There was a discussion as to the proper time for holding the annual conference of presidents and secretaries of county medical societies in Columbus. On motion by Dr. Davis, seconded by Dr. Micklethwaite, and carried, The Council recommended that this conference be held during the month of February. (Note: Date of Sunday, February 22, was selected as the date and the Fort Hayes Hotel chosen as meeting place.)

The Council then convened in executive session for the purpose of discussing the finances of the Association and establishing a budget for activities of the Association during 1948.

On motion by Dr. Brindley, seconded by Dr. Worstell, and carried, the report of the committee and the following budget for 1948 were approved:

BUDGET FOR 1948

The Ohio State Medical Journal.....	\$10,000
Executive Secretary, Salary.....	9,000
Executive Secretary, Expense.....	1,500
Stenographic and Clerical Personnel.....	10,900
President, Expense	800
Council, Expense	2,000
A.M.A. Delegates, Expense.....	2,000
Committee on Public Relations and Economics	1,000
Department of Public Relations (See Below)	30,300

Salary of Director.....	\$7,500
Director, Expense	1,500
Assistant Director	4,300
Assistant Director, Expense..	500
Speakers Bureau	1,000
Literature	7,500
Postage and Supplies.....	2,000
Newspaper Publicity and Exhibits	5,000
Miscellaneous Expense.....	1,000
Committee on Education.....	300
Postgraduate Programs.....	2,500
Conference County Society Presidents and Secretaries	1,500
Committee on Industrial Health.....	200
Committee on Medical Care of Veterans	500
Committee on Medical Service Plans...	500
Committee on Rural Health.....	500
Committee on Scientific Work.....	1,000
Committee on Auditing and Appropriations	100
Committee on National Emergency Medical Service.....	200
Committee on Cancer.....	500
Miscellaneous Committees	200
Stationery and Supplies.....	1,500
Postage, Telephone, and Telegraph.....	2,500
Rent, Insurance, and Bonding	6,000
Annual Meeting	15,000
Employees' Retirement Fund.....	2,500
Professional Relations Activities.....	3,000
Transfer to Permanent Reserve Fund...	30,000
Contingent Unassigned.....	4,000

On motion by Dr. Messenger, seconded by Dr. Swartz, and carried, The Council expressed sincere appreciation to the members of all committees of the Association who had worked so faithfully and efficiently during the past year.

WORKMEN'S COMPENSATION FEES

Several communications from members suggesting an increase in the Workmen's Compensation Medical and Surgical Fee Schedule, especially items involving office, home, and hospital calls, were read and discussed. On motion by Dr. Bowman, seconded by Dr. Davis, and carried, Dr. Worstell, chairman of the Committee on Industrial Health and Workmen's Compensation, and the Executive Secretary were instructed to meet with the Industrial Commission and request the Commission to consider the following changes in the fee schedule:

First treatment at office (day), \$5.00—now \$3.00.
First treatment at home or hospital (day), \$7.00—now \$5.00.
First treatment at office, home, or hospital (night emergency between 9:00 p.m. and 7:00 a.m.), \$10.00—now \$7.00.
Subsequent treatment at office, including or-

dinary medication and dressings, \$3.00—now \$2.00.

Subsequent treatment at home, including ordinary medication and dressings, \$4.00—now \$3.00.

Subsequent treatment at hospital, \$3.50—now \$2.50.

Tendon (finger) repair of: One tendon, \$75.00—now \$30.00.

Additional tendons, each, \$37.50—now \$15.00.

MAGAZINE ARTICLE DISCUSSED

A communication, calling attention to an article which appeared in the *Woman's Home Companion* entitled "How to Pick a Doctor" and newspaper advertising by that magazine on this subject, was read and discussed. The communication suggested that the State Association take suitable action to refute publicly the views on specialization and certification expressed in the article, charging that the article is contrary to the welfare of general practitioners, patients, and the medical profession as a whole. On motion by Dr. Swartz, seconded by Dr. Bowman, and carried, The Council expressed itself as believing that any effort toward having that magazine publish a retraction would be futile and would merely emphasize the complaints referred to; that should any effort towards a retraction be instigated, such effort should be made by the American Medical Association as the magazine is of national circulation; and that it would be more advisable for the Association to prepare its own articles on this subject for dissemination among the laity than to engage in any controversy with newspapers and periodicals relative to articles which they may publish, or have published, with which the medical profession might disagree. In this connection it was announced that the Public Relations Department of the Association has in mind the preparation of material on this and other subjects about which there seems to be considerable confusion in the minds of the public.

SCHOOL HEALTH PROGRAM

Reports from Dr. Carl A. Wilzbach, Cincinnati, Chairman of the Committee on Education, and Dr. J. W. Wilce, Columbus, who officially represented the Ohio State Medical Association at the conference on school health, held in Chicago in October under the auspices of the American Medical Association, were reviewed by The Council. On motion by Dr. Davis, seconded by Dr. Swartz, and carried, the recommendations of Dr. Wilzbach and Dr. Wilce, that the Ohio State Medical Association establish a committee on school health and request each county medical society to establish a local committee on school health, were approved.

At the suggestion of Dr. Wilce in his report, The Council reviewed the action of the House of

Delegates of the American Medical Association at the Atlantic City meeting in June, 1947, on this question. A resolution which had been presented by Dr. Sherburne, an Ohio delegate, and which was adopted by the House of Delegates of the A.M.A., reading as follows, was endorsed by The Council on motion by Dr. Brindley, seconded by Dr. Swartz, and carried.

"Whereas, The establishment of a central, coordinating unit to administer programs of health and medical services and health educational activities in universities, colleges, secondary school systems, and industry is being attempted in many communities in an effort to bring about efficient and economical operation of such programs; therefore be it

"Resolved, That so far as practical, the administration of such programs should be under the leadership and control of a doctor of medicine, possessing administrative ability and with experience and training in the techniques of preventive medicine and health education."

MISCELLANEOUS BUSINESS

A communication from the secretary of the Wyandot County Medical Society, asking that the State Association provide it with a copy of the official charter of that society, was read. The Executive Secretary was instructed to have such copy made and to submit to the House of Delegates at the 1948 Annual Meeting a request for authorization for re-issuance as required by the Constitution and By-Laws.

A request from the Crippled Children Services of the State Department of Public Welfare, that The Council approve a rheumatic fever and cardiac disease program planned by the Division for certain counties in Southwestern Ohio, was considered and the revised program as outlined in a memorandum was thoroughly discussed. On motion by Dr. Bowman, seconded by Dr. Davis, and carried, The Council voted **not to approve or endorse** the proposed rheumatic fever program on the grounds that there was insufficient evidence at this time to show the need for the expenditure of State or Federal funds for the activities proposed.

A letter from Mr. H. G. Jim Hays, General Manager of the Ohio State Safety Council, requesting the Ohio State Medical Association to name an official representative on the Board of Control for the Ohio Safety Council, was read and discussed. On motion by Dr. Messenger, seconded by Dr. Micklethwaite, and carried, President Rutledge was authorized to name such a representative.

Dr. Mundy informed The Council of the splendid cooperation which the Executive Committee of Ohio Medical Indemnity, Inc., has received from Mr. Charles H. Mylander, Vice-President, Huntington National Bank, and Mr. E. C. Pohlman,

Superintendent of Grant Hospital, Columbus, as members of the Executive Committee, and he moved that The Council express sincere appreciation to Mr. Mylander and Mr. Pohlman for their efficient services and untiring efforts on behalf of Ohio Medical Indemnity, Inc. The motion was seconded by Dr. Worstell and unanimously adopted.

Dr. Swartz presented a communication which he had received from Dr. Stanley Dorst, Dean of the University of Cincinnati College of Medicine, relating to the blood transfusion program of the American Red Cross. The letter was accompanied by a critical report of the program prepared by Dr. Dorst and Dr. Carter, Professor of Surgery, University of Cincinnati College of Medicine. Inasmuch as The Council had not had an opportunity prior to this meeting to study the report, the question was referred to the Committee on Public Relations and Economics for consideration and action.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

College of Surgeons in Toledo

The American College of Surgeons has scheduled six section meetings in 1948, the first of which will be held January 20 and 21 at the Commodore Perry Hotel in Toledo. Each meeting will include conferences for hospital personnel as well as sessions for members of the medical profession.

Each day will begin with the showing of medical motion pictures. There will be luncheon meetings both days, and a dinner meeting the first evening. Panel discussions on scientific subjects in each field of surgery will be held morning and afternoon. Subsequent meetings will be held in Atlanta, Oklahoma City, Denver, Minneapolis, and Halifax.

Urology Seminar at Michigan

A two-day postgraduate program in urology and related sciences is being offered January 28 and 29 by the Postgraduate Medicine Department of the University of Michigan under sponsorship of the Detroit Urological Society. The lectures and clinics have been selected to interest the specialists in both practice and basic knowledge of urology. The fee is \$15. Requests for further information should be addressed to Howard H. Cummings, M.D., Department of Postgraduate Medicine, University of Michigan, Ann Arbor.

A one-reel film entitled "Immunization" is available from the Encyclopedia Britannica Films, Inc., Chicago, to be used in teaching biological sciences in junior and senior high schools.

Annual Conference of County Society Officers To Be Held in Columbus, February 22

Just as this issue of The Journal was going to press, February 22 was selected as the date for the Annual Conference of County Medical Society Presidents and Secretaries and officers of the Ohio State Medical Association. The meeting will be held at the Fort Hayes Hotel, Columbus. Details of the program and invitations will be sent to the county society officers within a few weeks. These officers should reserve Sunday, February 22, for this important conference. It will be worth attending.

Casket Regulation Is Permanent

Regulation 51-a of the Public Health Council of the Ohio Department of Health, aimed at preventing the opening of hermetically-sealed caskets of returning war dead, has become a permanent regulation of Ohio's Sanitary Code following a hearing on this matter, held in Columbus, December 6. As reported in the December issue of *The Ohio State Medical Journal*, the regulation will apply to the "opening of a hermetically-sealed casket containing the disinterred remains of persons dead from any cause, and transported into this state for burial".

Need Medical Officers For Canal

According to a letter from the Washington office of the Panama Canal, there is an urgent need for a number of medical officers for duty in the Canal Zone. The positions open are in the professional grades of P-3 and P-4 at entrance salaries of \$5187 and \$6127.50 per annum, respectively. Appointment to the P-4 grade may be made of applicants who have had three or more years' experience subsequent to internship. Applicants may address The Chief of Office, The Panama Canal, Washington 25, D. C.

Clinical Conference, March 2-5

An intensive four-day postgraduate course for the general practitioner and the specialist will feature the Fourth Annual Clinical Conference of the Chicago Medical Society at the Palmer House, Chicago, March 2-5. To be included are morning and afternoon lectures, panel discussions, a clinicopathologic conference, and round-table discussion, to cover new methods of diagnosis and treatment. Both scientific and technical exhibits will be presented.

Preliminary Plans for 1948 Annual Meeting, Cincinnati, March 30-April 1, Made at Conference in Columbus on November 23; Schedule of Events Formulated

MORE than 40 physicians—officers and members of the program committees of the scientific sections—met in the Headquarters Office of the Ohio State Medical Association on Sunday, November 23, to complete preliminary plans for the 1948 Annual Meeting of the Association, March 30-April 1, inclusive, Netherland Plaza Hotel, Cincinnati.

Dr. Louis G. Herrmann, Cincinnati, chairman of the Committee on Scientific Work, presided at the conference.

Reports were received by representatives of each of the scientific sections, presenting suggested subjects and speakers for the section sessions and recommendations for subjects and speakers for general sessions.

Also, there was a discussion of subjects which should be presented at the instructional courses—a popular feature of the 1947 Annual Meeting which will be repeated next year.

SCIENTIFIC EXHIBIT

Dr. William F. Ashe, Cincinnati, chairman of the Committee on Scientific Exhibit, reported that his committee has been accepting applications and that the prospects are for one of the largest and best scientific displays in the history of the Association. Section representatives were requested to assist the committee in securing additional acceptable exhibits.

Executive Secretary Nelson announced that all space in the Technical Exhibit has been sold and that arrangements for the Annual Banquet on Wednesday evening, March 31, are being completed.

The general conference was adjourned at noon after which the Committee on Scientific Work met for the purpose of reviewing the program material presented by the scientific section representatives; discussing subjects and speakers for the general sessions and the instructional courses; and other details.

PROGRAM TO APPEAR IN FEBRUARY

Plans are being made to publish the complete Annual Meeting program in the February issue of *The Ohio State Medical Journal*. A direct mail folder on the meeting will be sent to all members in mid-February.

Those planning to attend the Cincinnati meeting should secure hotel reservations at the earliest possible date. A blank for se-

curing accommodations will be found in this issue of *The Journal*. Similar blanks have appeared in several recent issues of *The Journal*.

SCHEDULE OF EVENTS

Following is the official time schedule and schedule of events for the Cincinnati meeting:

TUESDAY, MARCH 30

9:00 A.M.-12:00 Noon

Meetings of the Following Scientific Sections:

Section on Medicine

Section on Anesthesiology

Section on Obstetrics and Gynecology

1:30-3:00 P.M.

Instructional Courses

3:15-5:00 P.M.

First General Session

6:30 P.M.

Dinner for Members of House of Delegates
Business Session

WEDNESDAY, MARCH 31

9:00 A.M.-12:00 Noon

Meetings of the Following Scientific Sections:

Section on General Practice

Section on Public Health and Preventive
Medicine

Section on Eye, Ear, Nose, and Throat

1:30-3:00 P.M.

Instructional Courses

3:15-5:00 P.M.

Second General Session

7:30 P.M.

Annual Banquet

THURSDAY, APRIL 1

9:00 A.M.-12:00 Noon

Meetings of the Following Scientific Sections:

Section on Surgery

Section on Nervous and Mental Diseases

Section on Pediatrics

12:30 P.M.

Luncheon for Members of House of Delegates
Business Session

1:30-3:00 P.M.

Instructional Courses

THOSE WHO ATTENDED

Those who attended the November 23 conference on Annual Meeting arrangements and program were: Dr. Louis G. Herrmann, Cincinnati, chairman, Committee on Scientific Work; Dr. M. Paul Motto, Cleveland, and Dr. Charles A. Doan,

Columbus, members, Committee on Scientific Work; Dr. Ralph L. Rutledge, Alliance, president, and Dr. A. A. Brindley, Toledo, president-elect, Ohio State Medical Association; Dr. Jonathan Forman, Columbus, editor, *The Journal*; Dr. R. J. Whitacre, Cleveland; Dr. Carl R. Damon, Mansfield; Dr. A. L. Schwartz, Cincinnati; Dr. Paul L. Yordy, Dayton; Dr. George F. Collins, Columbus.

Dr. Russel G. Means, Columbus; Dr. Horace W. Reid, Cincinnati; Dr. Ralph M. Miller, Cincinnati; Dr. S. C. Yinger, Springfield; Dr. Emil R. Swebston, Cincinnati; Dr. J. G. Lemmon, Akron; Dr. S. D. Nielson, Elyria; Dr. L. E. Anderson, Greentown; Dr. Neil Millikin, Hamilton.

Dr. Ralph M. Watkins, Cleveland; Dr. Leon Schiff, Cincinnati; Dr. T. P. Sharkey, Dayton; Dr. F. W. Ansinger, Jr., Springfield; Dr. Philip Piker, Cincinnati; Dr. D. M. Palmer, Columbus; Dr. Harrison S. Evans, Columbus; Dr. A. T. Hopwood, Cambridge.

Dr. J. L. Reycraft, Cleveland; Dr. Richard D. Bryant, Cincinnati; Dr. R. K. Ramsayer, Canton; Dr. George M. Wilcoxon, Alliance; Dr. Allan C. Barnes, Columbus; Dr. W. B. Taggart, Dayton; Dr. John Edwin Brown, Jr., Columbus; Dr. George C. Malley, Zanesville; Dr. Floyd P. Allen, Cincinnati; Dr. John D. Porterfield, Columbus; Dr. J. E. Purdy, Canton; Dr. Robert M. Zollinger, Columbus; Dr. Vinton E. Siler, Cincinnati; Dr. Max T. Schnitker, Toledo; Dr. Frederick T. Merchant, Marion; Executive Secretaries Nelson and Saville; and Hart F. Page, news editor, *The Journal*.

Naturopaths' Suit Ruled Out

In a decision announced December 10, Franklin County Common Pleas Judge John R. King refused a declaratory judgment ordering the Ohio State Medical Board to issue licenses for the practice of naturopathy.

This decision sustained a demurrer to the suit of William L. Arnett, Columbus, and others, the petition of which was abstracted in the October, 1947, issue of *The Ohio State Medical Journal*.

Judge King intimated that the naturopaths should take their "complaint" to the General Assembly rather than to the court.

Education and Licensure Congress,

The American Medical Association has announced the 44th Annual Congress on Medical Education and Licensure, which will take place February 9 and 10, in the Red Lacquer Room of the Palmer House, Chicago. The congress will be in session from 9:30 a.m. to 5 p.m. each day.

New Members of State Medical Association

New members of the Ohio State Medical Association since the December, 1947, issue of *The Journal* was issued are:

Clark County

Howard E. Sanders, Springfield

Columbiana County

A. P. Falkenstein, Salem

Cuyahoga County

John C. Richards, Cleveland; Robert Rogoff, Cleveland; David N. Rudin, Cleveland; Victor M. Victoroff, Cleveland

Franklin County

Kenneth H. Abbott, Columbus; William R. Caland, Columbus; Lloyd R. Evans, Columbus (temporary address, Brookline, Mass.); George J. Hamwi, Columbus; Philip D. Hardyman, Columbus; Wendell P. Scott, Columbus; Edward V. Turner, Columbus; Wm. V. Whitehorn, Columbus (temporary address, Villa Park, Ill.)

Hamilton County

Harold A. Cassady, Cincinnati; James W. Coombs, Cincinnati; Kamillo Flachs, Cincinnati (temporary address, Ft. Harrison, Mont.); Daniel J. Westerbeck, Cincinnati

Huron County

Wm. R. Roasberry, New London; Thomas H. Wells, Norwalk

Jefferson County

Lester Stein, Steubenville

Lorain County

Richard Burger, Lorain; John Hertner, Avon; Dudley B. Reed, Oberlin

Montgomery County

Harry E. Dick, Dayton; Joseph A. Eisenberg, Dayton; Ernest L. Fox, Dayton; Howard E. McKnight, Dayton; David Migdoll, Dayton; John H. Paschold, Dayton; C. Richard Price, Dayton; Stanley Vangrov, Dayton

Richland County

Wendell M. Bell, Mansfield; Russell C. Long, Mansfield; Robert W. Wolford, Mansfield

Stark County

V. E. Kaufman, Canton; S. Earl Kerr, Massillon

Summit County

Everett F. Hurteau, Akron

"Get In and Pitch", Baruch Advises Doctors in Speech Suggesting Elements for National Health Program

ON November 19, Bernard M. Baruch addressed a banquet at the Biltmore Hotel, New York City, sponsored by the Medical Society of the State of New York, the Coordinating Council of the Five County Medical Societies of Greater New York, and the Greater New York Hospital Association.

Because of Mr. Baruch's fame as an international statesman, Congressional and Presidential adviser, and trouble-shooter de luxe, his remarks on that occasion received widespread publicity in the press and on the radio.

One editorial writer expressed the wish that "every doctor in the country could have heard" his address.

A Washington observer suggests that Mr. Baruch's talk "may have important bearing upon three pieces of major legislation" before the Congress.

Harold L. Ickes in his column states he "wrote a prescription for a much needed health insurance program for those in low income groups", adding that some of the physicians who heard him "inevitably must have clenched their teeth and refused to swallow what they regarded as a nostrum".

Obviously, the so-called sensational parts of Mr. Baruch's talk were the ones which got the headlines. For example, great emphasis was placed on his suggestion that some form of insurance covering the low-income groups "by law and financed by the government, at least, in part" appears to be the only answer to the question—the need for more medical care.

But, Mr. Baruch said many other things. He offered a great many practical suggestions—suggestions which should be seriously considered by physicians and laymen.

There will be no unanimity of opinion on his comments and recommendations. Baruch himself is too realistic to believe in miracles. Nevertheless, he realizes that many of his ideas and suggestions will receive the applause of realistic members of the medical profession, even though they may disagree with him on a few.

Just what did Mr. Baruch say?

So Ohio physicians may have the opportunity to study all of his suggestions—not just those which hit the headlines or made good fodder for the columnists—*The Journal* lifted the following text of Mr. Baruch's speech from the Congressional Record of November 20 where it was printed by the request of Congressman Francis J. Myers, Pennsylvania:

MEDICAL CARE AND THE NATIONAL HEALTH

(An address by Mr. Bernard M. Baruch)

YOU do me honor to ask me to talk to you about health. I almost became a doctor myself.

When I was a boy, my mother took me to a phrenologist. His office was across the street from where Wanamakers now is. He felt the bumps on my head and asked my mother what she expected to do with me.

She replied: "I am thinking of making him a doctor."

"He will be a good doctor," said the phrenologist," but my advice to you is to take him where they are doing things in finance and politics—he might even make good there, too."

It has been a long detour for the prodigal. He has returned.

In many ways I am sorry I did not become a member of this noblest of professions. For I believe we approach a great adventure in health. That is our goal. I think it obtainable. It would be gratifying to take a more active part in it.

All my thoughts on medicine are colored by memories of my father, Dr. Simon Baruch. He was the wisest man I ever knew. He pioneered in surgery, physical medicine, and "incurable diseases". Often I heard him tell prospective medical students:

"Do not enter the medical profession to make money. Study medicine only with the idea that your greatest compensation will be knowing that you help your fellowman. Do not expect gratitude and you will never be disappointed."

As Chairman of the War Industries Board in the First World War, I realized how important to defense was the health of our citizens. That awareness was reinforced many fold during this past war.

In preparing a report for the late President Roosevelt on manpower, I was shocked to learn at least 4,000,000 men had been rejected as

IV-F's—unfit to defend their country. Some, not all, of these defects were preventable.

How much more shocking would have been the record, if everyone had received the same examination?

Since then, I have given the problems of medical care much thought. It deeply concerned me that we not fail the returning veterans, so I studied their medical needs. From that, it was only a step to related problems of general medical care for all.

Soon I was up to my neck in reports, statistics, speeches, congressional hearings. I conferred with many persons, doctors, and nondoctors, experts, and amateurs.

May I tell you some of my conclusions. They may not be particularly new to you, pioneering this field. They may be helpful, coming from a nonprofessional mind.

But before I list them, I would like to point out that the medical science and art have conferred a new and great benefit upon society in the last generation. The years of our lives have been heavily increased. This helps not merely the individual, who wants to go on living—and living in dignity and self-respect—but all the people to live more comfortably and freer from fear.

And now to go on with my exposition:

There is no question—the need for more medical care exists.

Also, there is no question this need will have to be met.

The problem is how?

All over the world, the masses are stirring for higher living standards. Improved medical care is a foundation of that better standard. Without good health, of what advantage are higher wages or shorter work hours, better education or greater leisure?

The families whose earnings disappear with serious illness—the many who suffer disease which your skillful diagnosis and treatment could have prevented or halted—or whose limited means bar them from the medical attention available to you and me—these people will not remain content.

This striving of the masses for better living is felt everywhere. In health, your profession must steer that surging tide into channels of improvement. Then, the surge does not overflow into the revolutionary flood, which washes away more than it brings.

One of the last things Woodrow Wilson wrote—called “The Road Away From Revolution”—was this:

“In these doubtful and anxious days when * * * the road ahead seems darkened by shadows, which portend dangers of many kinds, it is only common prudence that we should look about us and attempt to assess the causes of

distress and the most likely means of removing them.”

That was Wilson's method—to assess portending dangers, and anticipate them by timely action. So he proposed the realistic League of Nations, which men rejected as a dream—and got a nightmare. Wilson knew social change was inevitable. He worked to steer that change into orderly channels.

You should take that as your guiding star.

Society usually divides into three broad groups.

At one end—the left end—are those who burn with a passion to change everything as quickly as they can—if not quicker.

At the other—right end—are those who want things just as they are.

In the middle are people, like Woodrow Wilson, to whose school I belong, who believe in intelligent progress and seek to guide it.

What differentiates these three groups is their attitude toward that vital element of life—time.

The left-enders feel time panting hot on their necks.

The right-enders use time to fight rearguard actions, all the way.

The middlers—sometimes both left and right call us muddlers—seek to come to terms with time, preserving the best of the past, discarding the outworn, and moving on to a better future.

In the matter of adequate medical care, too many doctors have been fighting a rearguard action for too long. I feel I must warn those doctors—time is running against them. The medical profession has justly earned great influence in the community. It can keep that hold only as it moves forward. It will lose that hold if it has nothing but objections to offer, if it has eyes only for what not to do.

We must look for what can be done—and do it.

The great question is how? I do not want to seem to say I know the answers. We do know the public is demanding better and more medical service through some action, political or otherwise.

What is this adventure in health I see dawning, and toward which you all have been keeping the doctor's vigil through the night? This adventure, which you will have to lead—or it will fail—has many elements:

1. More and better doctors in more places.
2. An immediate, complete survey to modernize medical education, with greater emphasis on chronic and degenerative diseases, mental hygiene, and preventive medicine.
3. More hospitals more evenly spread through the country.
4. Less specialists; more general practitioners.
5. Reorganize medical practice, stressing group medicine where needed and voluntary health insurance.

6. For those who cannot afford voluntary insurance, some form of insurance, partly financed by the Government, covering people in by law. I would call this "compulsory health insurance", if that term's proper meaning had not been lost.

7. Increased medical research.

8. Greatly expanded physical and mental rehabilitation.

9. Education to make health a national habit.

10. A vigorous, preventive medical program, reaching everyone—children above all.

11. A new Cabinet post for health, education, social security.

12. Creation of a nonpolitical watchdog committee to safeguard progress in medical care for veterans.

13. Increased numbers of well-trained nurses and technicians.

14. Adequate dental care.

15. A stabilizing economy—inflation will make worthless any health program or anything else.

Each of these would take a speech by itself. I can but sketch some of them.

Even the least ambitious schemes for improving the Nation's health require more doctors, all competently trained. Why aren't more doctors being educated? In studying that question, I was struck by how expensive training a doctor has become—in dollars and in time. In its fine report on "Medicine in the Changing Order", the New York Academy of Medicine states:

"There seems no alternative other than Government aid if educational standards are to be raised or even maintained. * * * If medical schools are to continue as centers of research * * * here also Government aid may be necessary."

If science and medicine ask the Government for aid—which even the conservative deems necessary—they must expect he who pays the fiddler will call the tune. This means the Government will rightly insist upon no discrimination in medical care because of race, color, or creed. It will rightly insist upon opportunity for all to enter the profession and advance on the sole basis of ability and character—without restrictions of race, color, creed—or sex. And I hope, without fear of, or favor from, the State.

Minimum standards should be set for institutions getting financial aid.

How much more the Government is likely to insist upon will depend upon the more progressive leaders in your profession.

According to the academy's report—I quote: "There has been no fundamental reorganization of American medical education since about 1910." That finding certainly calls for your profession undertaking—now—a most thorough, down-to-earth survey to modernize medical education, making recommendations so boldly inspir-

ing the people will gratefully back them. No one can draw up a better program than doctors.

Chronic illness and preventive medicine deserve greater attention. In all fields—I hope in war as well—there is a new accent on prevention. From answering fire alarms, our thinking is progressing to fireproofing.

Preventive medical care should commence as close to the beginning as society can reach. I favor a major, sickness-prevention drive at the public school level. This should include compulsory examination of all children at regular intervals. Means should be made available for correcting defects disclosed.

How wonderful, if children were taught how to properly eat, sleep, sit, stand, play, and take care of themselves, developing both the knack for getting along together, and self-discipline—physical and mental.

Even when medical care is available, many adults neglect or refuse to use it—often because of social taboos, as in venereal diseases, or psychological dreads, as in cancer and tuberculosis. These attitudes reflect our not having outgrown the awkward age in thinking about disease and health. We do not really have a grown-up, national health habit—although we are getting there.

People need to be educated on the virtue of medical care; how to use it; how to prevent disease. The greatest asset of any nation is a healthy, educated citizenry.

And now to what is perhaps the toughest problem—how can better medical care be extended to those who cannot afford it?

Your organizations have been particularly active in pressing voluntary health insurance. You and others have proven group insurance to be a sound, practical way. That is a great achievement. You can be mighty proud of it.

But I would not be frank—nor friendly—if I did not add what you know. It is not good enough.

Rome was not doctored in one day. It may be, as some have told me, that the needs of the bulk of our people can be met, given time, through voluntary insurance. What troubles me most are the needs of that sizable segment of society, which does not earn enough to pay for voluntary insurance.

The American Medical Association—its bureau of medical economics—estimated in 1939 that families earning \$3,000 or less—two-thirds the population—cannot afford the cost of serious illness. Some of these can afford voluntary insurance, although inflation has reduced their number. But what of the little fellows who cannot?

I have asked that of nearly everyone with whom I have discussed medical care. Nothing has been suggested so far which promises success other than some form of insurance covering

these people in by law and financed by the Government, at least in part—what some would call compulsory health insurance.

Since doctors, nurses, technicians, and hospitals already are strained, such insurance probably would have to move in stages. That requires careful study. Any program should utilize existing medical facilities to the maximum—it must to get started—and be organized to the local level.

Nationally, the program might well be administered by a body of doctors and nondoctors to keep medical care as free from politics as possible.

As to financing, my own preference runs toward the Government meeting only part of the cost, with part coming from payroll deductions from employers and workers. In time, these deductions will become absorbed in general costs of production. I have the utmost confidence in the efficiency of American industry—both labor and management—and which good health will stimulate. We can absorb these medical costs better than other countries which must also meet these needs.

The detailed problems raised by so-called compulsory health insurance are too numerous to be discussed tonight. I have weighed them most carefully. Many doctors and many lay people have sought to paint this issue as a choice—all black or all white. I have found every aspect of medical care to be gray—the happy color sensible compromise wears. All law imposes compulsion. A form of compulsory health insurance for those who cannot pay for voluntary insurance can be devised, adequately safeguarded, without involving what has been termed “socialized medicine”. The needs can be met—as in other fields—without the Government taking over medicine, something I would fiercely oppose.

Law protects society. It is the absence of law which destroys it.

I do not fear government taking its legitimate part in medicine, any more than I fear it in education or housing. There should be just one Federal agency, with Cabinet rank, for all health and human welfare problems. I do not like Government agencies to be like Mahomet’s coffin, suspended between heaven and earth.

Some say many people do not know how to pick their doctors. So with any human activity. The best insurance against poor choice is improving the general quality of all doctors. But, good or poor, it must be the patient’s choice. No one else’s.

May I interject this about inflation? Should health schemes fail, be sure to ask—were they killed by the plan itself—by incompetent administration—or by an inflation which ruined the plan’s financing.

In connection with this doctor-government relationship, it is a pleasure to point to the excel-

lent medical progress in the Veterans’ Administration—thanks primarily to Gen. Omar Bradley and Gen. Paul Hawley. They would never have accomplished their good work had they not refused to allow the politicians to move in on them.

I would like to see the President name a small committee of top-grade citizens—some doctors, some lay people—to act as a vigilant watchdog over the veterans’ medical program, so the ground so arduously gained may not be lost when someone replaces General Bradley. He should be supported by the entire Nation—particularly by doctors. His is the kind of courage and vigilance which will assure good administration of any health program.

More doctors must be distributed to more places in the country, which requires, among other things, less stress on training specialists, more on general practitioners. A number of counties do not even have a doctor. This reflects, in part, a lack of facilities in which doctors can work. Happily, some of this will be corrected under the Hill-Burton Act for hospital construction, with Federal and State governments co-operating.

Orderly change is the American way of life. Remember the spirit of your Oath of Hippocrates. Use your own good judgment to move along with humanity’s legitimate aspirations in its trek toward better living.

I would hate to see any medical care program under guidance of others than those who have the know-how. So would the American people. That is why I urge the doctors to get in and pitch—not stand by on the side lines. You need fear politicians or bureaucrats only to the degree you fail yourselves. You must take the leadership—no—yours is now the leadership. Keep it.

This meeting is an outstanding example of your deep concern to meet the need for action.

I have met people in all fields of human endeavor. I respect no group more—for your unselfish zeal and devotion to the sick, for the jealousy with which you guard your professional virtue—placing beyond the pale the rare violator of your oath.

I envy you the thrill which comes from relieving a patient from pain and, often, snatching one from death.

I still am sorry that phrenologist didn’t let me become a doctor.

Your situation reminds me of something my father said back in 1873, while president of the South Carolina Medical Society:

“Let us not be silent, but offer our facts, and defend them while we may.

“As an Arabian sage has said, ‘What good comes from Ali’s sword if it be sheathed?

“‘What good from Sadi’s tongue, if it be silent?’”

Ohio Hospital Advisory Council Appointed; Health Department Preparing Report for Surgeon General

THE State Director of Health, Dr. John D. Porterfield, with the approval of the Governor of Ohio, has appointed a 16-member Hospital Advisory Council to act as an advisory body to the department in connection with the administration of the Hill-Burton Federal hospital construction program in Ohio.

DR. RUTLEDGE NAMED

Dr. Ralph L. Rutledge, Alliance, president of the Ohio State Medical Association, was named to the council for three years under the regulations providing that "four members of recognized ability in the field of medicine or surgery" were to be selected. Others in this category were Dr. George A. Woodhouse, Pleasant Hill, member of the Committee on Public Relations, Ohio State Medical Association, for a term of two years; Dr. Edward J. Humphreys, acting chief, Division of Mental Hygiene, State Department of Public Welfare, one year; and Dr. Joseph B. Stocklen, Cleveland, Controller of Tuberculosis for Cuyahoga County, four years.

Charles S. Nelson, Columbus, executive secretary, Ohio State Medical Association, was named to the council as one of the "four individuals of recognized ability in the fields of nursing, welfare, public health, architecture, or allied professions in the field of health". Others in this classification were A. David Bouterse, Columbus, executive director, Ohio Welfare Council, to serve for one year; Charles F. Owsley, Youngstown, an architect, for three years; and Miss Mabel Selin, R. N., nurse educator, administrator, Magruder Memorial Hospital, Port Clinton, for a four-year term.

HOSPITAL ADMINISTRATORS

Representing hospital administration, the following were appointed: Dr. M. F. Steele, superintendent, Christ Hospital, Cincinnati; W. L. Benfer, superintendent, Toledo Hospital; R. M. Porter, Children's Hospital, Columbus; and Guy J. Clark, executive secretary, Cleveland Hospital Council, for one, two, three, and four years, respectively.

The following were appointed as "individuals with broad civic interests representing consumers of hospital services": Miss Doris G. Chandler, executive secretary, Metropolitan Health Council of Dayton and Montgomery County, one year; Artee Flemming, Akron, attorney, and president of the Akron Frontiers Club, two years; Harry W. Culbreth, Columbus, organization director, Ohio Farm Bureau Federation, three years; and Joseph W. Fichter, Master, The Ohio State Grange, for four years.

Ex officio members will be Dr. Porterfield, who will serve as chairman, and Charles L. Sherwood, director, Ohio Department of Public Welfare.

IS ADVISORY IN NATURE

The council is advisory in nature, and will assist the State Director of Health in determining policies incidental to the administration of the survey itself, which has already been completed.

The Director will be assisted in these duties by the Office of Hospital Planning which is headed by A. J. Borowski, D. P. H., former registrar and superintendent of the Bureau of Vital Statistics, Toledo Board of Health.

WILL SUBMIT PLAN

As this was written plans were underway for a meeting of the Advisory Council on December 30 at which time a complete plan, entailing Part I, a general report of the results of the survey, and Part II, a statement of the proposed operating procedures, will be considered for submission to the Surgeon General of the United States Public Health Service for approval. This approval is necessary in order for the individual agencies involved in constructing hospitals to obtain the subsidy of one third of the total construction cost, to be provided by the Federal Government.

If the approval is granted by the Surgeon General, it is anticipated that the Director of Health may be in a position to accept applications for participation in the plan about March 1.

PROGRAM OF INFORMATION

In the meantime, the Office of Hospital Planning is engaging in a program of information to make sure that all communities in Ohio will know about the program, especially rural communities with high priorities, so that they will be ready to apply for participation when the State Department of Health is ready to receive their requests.

Dr. McNamee Honored by Radiologists

Dr. Edgar P. McNamee, Cleveland, past-president of the Ohio State Medical Association, was named president-elect of the Radiological Society of North America, during the annual meeting of that organization, held in Boston, November 30 to December 5. Dr. L. Henry Garland of San Francisco will serve as president in 1948.

Health Problems of Rural Children To Be Discussed at Conference of Doctors and Farm Leaders

THE American Medical Association with the cooperation of the American Academy of Pediatrics and representative national farm organizations, will sponsor the third annual National Conference on Rural Health, February 6 and 7, at the Palmer House in Chicago.

The theme of the conference will be one of the points of the National Health Program of the A. M. A., namely, "Every child should have proper attention, including scientific nutrition, immunization, and other services included in infant welfare."

The two-day program as announced by the A. M. A.'s Committee on Rural Medical Service, will include luncheon addresses by Joseph H. Ball, United States Senator from Minnesota, and Dr. Edward L. Bortz, president of the A. M. A.

HEALTH PROBLEMS OF RURAL CHILD

Leading off the conference on Friday morning, after opening speeches by Drs. F. S. Crockett, chairman of the A. M. A. Committee on Rural Medical Service, and George F. Lull, A. M. A. secretary and general manager, the "Health Problems of the Rural Child" will be discussed by Dr. Lee Forrest Hill, Des Moines, past-president of the American Academy of Pediatrics, and Mrs. Charles W. Sewell, Chicago, administrative director of the Associated Women of the American Farm Bureau Federation.

This will be followed by a discussion of the Study of Child Health Services of the American Academy of Pediatrics. Participants will include Dr. John P. Hubbard, Washington, D. C., director of child health studies for the academy; Dr. Katherine Bain, Washington, D. C., director, division of research in Child Development, Children's Bureau; and Dr. Henry G. Poncher, Chicago, chairman of Illinois Child Health Studies of the American Academy of Pediatrics.

RURAL YOUTH AND WORLD WAR II

Next on the agenda is a paper on "Rural Youth and World War II", by Dr. Maurice H. Friedman, Washington, D. C., followed by another on "Child Psychology", by Dr. Margaret W. Gerard, Chicago, consultant for the Illinois Children's Home and Aid Society.

The afternoon session will begin with a panel on "Rural Public Health Organization" with discussion by Mrs. Gladys Talbott Edwards, Denver, director of education, Farmers Educational and Cooperative Union; Dr. Florence R. Sabin, Denver, chairman, Interim Board of

Health; and Lon W. Morrey, D.D.S., Chicago, editor of *The Journal of The American Dental Association*.

"The Olmstead County Child Health Project" will be discussed by Dr. Floyd M. Feldman, Rochester, Minnesota, director of that organization, as the next item on the program.

YOUNG PEOPLE ON PROGRAM

Winding up Friday's activities will be a round-table discussion on "Rural Youth Looks at Health", led by Edward H. Mertz, Denver, executive secretary of the Farmers Educational Foundation, and with the following young people participating: Miss Martha Kohl, Corfu, New York, representing the Young Cooperators organization of the National Cooperative Milk Producers Federation; Miss Betty Chandler, Jamestown, N. D., youth committee of the Farmers Union; Robert McCoy, New Vienna, Ohio, youth committee of the National Grange; and Miss Ruth Parsons Fowlerville, Michigan, youth committee of the American Farm Bureau.

Opening the conference Saturday will be a round-table discussion on "The Rural School Health Program", with the following participants: Dr. G. F. Moench, Hillsdale, Michigan, chairman, National Advisory Committee of the Health and Summer Round-Up for the Parent-Teachers Association; Joseph W. Fichter, Columbus, chairman of the National Grange Health Committee; Mrs. J. Laning Taylor, Washington, D. C., director, Education Department, National Cooperative Milk Producers Federation; and Dr. Dean F. Smiley, Chicago, A. M. A. Bureau of Health Education. Frank W. Peck, Chicago, managing director of Farm Foundation will summarize.

MEDICAL SERVICE IN RURAL AREAS

Another panel discussion, on the subject, "Medical Service in Rural Areas", will also occupy the morning program. The leader will be Dr. James R. McVay, Kansas City, chairman of the Council on Medical Service of the A. M. A. Participants will be: Mrs. Ora Light Dykes, Murfreesboro, Tennessee, chairman of the National Grange Committee on Home Economics; Mrs. Eustace A. Allen, Atlanta, president of the Woman's Auxiliary to the American Medical Association; Dr. Vane M. Hoge, Washington, D. C., director, Division of Hospital Facilities, U. S. P. H. S.; Dr. Ralph V. Platou, New Orleans, head of the Department of Pediatrics, Tulane University School of Medicine; and Dr. H. B. Mulholland, Charlottesville, Virginia, member of the A. M. A. Committee on Rural Medical Service.

Summaries will be presented by Ransom E. Aldrich, Jackson, Mississippi, chairman of the Medical Care Committee of the American Farm Bureau Federation, and Dr. Clifford G. Grulee, Evanston, secretary and treasurer of the American Academy of Pediatrics. The luncheon, featuring the addresses of Senator Ball and Dr. Bortz, will follow.

TO REPRESENT O. S. M. A.

Dr. Carll S. Mundy, chairman of the Committee on Rural Health of the Ohio State Medical Association, and member of the A. M. A. Committee on Rural Medical Service, will officially represent the Ohio State Medical Association. One or more members of the Columbus Headquarters Staff of the Association will also attend.

Physicians Participate in District Rural Health Conference

On December 5, a District Rural Health Conference was held at the Court House, Wilmington. The conference was planned by the Ohio Rural Health Council which was assisted by representatives of the Committee on Rural Health of the Ohio State Medical Association in formulating the program. Local arrangements were handled by the Clinton County Health Council and Rural Policy Health Committee under the direction of Mrs. Arthur McCoy, New Vienna.

Approximately 140 members of rural health councils of 17 Southwestern Ohio counties, agricultural extension department workers, physicians, and state and local health workers attended. Presidents and secretaries of county medical societies in many of the counties were present, in addition to two members of The Council of the State Medical Association.

The theme of the meeting was "Establishing and Maintaining Effective Public Health Services". An address on that subject was made by Dr. Harry Wain, medical director of Miami Valley Hospital, Dayton, formerly health commissioner of Miami County. In his talk, Dr. Wain outlined the services which an up-to-date local health department should provide; how the work should be financed; and how lay groups can assist in the department. The subject from the standpoint of the nursing profession was discussed by Miss Gertrude Bush, chief of the Division of Nursing, Ohio Department of Health.

Following these addresses, reports on the activities of their local health departments were made by representatives of the rural health planning groups of the 17 counties. Following lunch, four group discussions were held at which ways and means of improving local health services were discussed informally by those in attendance. Reports of the group conferences were presented to the entire conference after which Dr. John D. Porterfield, director, Ohio Department of Health,

addressed the conference on the objectives, plans, and needs of the Ohio Department of Health. Cooperation of the medical profession with the rural health groups in their efforts to provide and maintain better health services for their areas was voiced by Charles S. Nelson, executive secretary of the Ohio State Medical Association.

Among those who attended the conference were: Dr. R. L. Lawwill, Seaman; Dr. R. B. Ellison, Peebles; Dr. H. A. Moore, Oxford; Dr. J. M. Coleman, Loveland; Dr. R. W. DeCrow, Dr. J. H. Frame, and Dr. Robert Conard, Wilmington.

Dr. Gordon E. Savage, Xenia; Dr. N. M. Reiff, Washington C. H.; Dr. F. A. Halloran and Dr. H. H. Ingling, Springfield; Dr. E. H. Schoenling, Dr. R. C. Rothenberg, and Dr. E. O. Swartz, Cincinnati; Dr. J. Martin Byers, Greenfield; Dr. Leland D. McBride and Dr. W. B. Roads, Hillsboro.

Dr. H. H. Pansing, Dr. Harry Wain, Dr. A. D. Cook, and Dr. T. L. Light, of Dayton; Dr. Carl W. Beane, Eaton; Dr. R. E. Bower, Chillicothe; Dr. Gilbert Micklethwaite, Portsmouth; Dr. A. F. Lippert, Pleasant Plain; Dr. Porterfield; and Mr. Nelson.

COMING MEETINGS

Ohio State Medical Association, Cincinnati, March 30-April 1.

American Medical Association, Interim Meeting of House of Delegates and Scientific Session for General Practitioners, Cleveland, Jan. 5-8.

American Medical Association, Third Annual National Conference on Rural Health, Chicago, Feb. 6 and 7.

American Medical Association, Joint Meeting of Council on Medical Education and Hospitals of the A.M.A., and Advisory Board for Medical Specialties, Chicago, Feb. 8.

American Medical Association, Annual Congress on Medical Education and Licensure, Chicago, Feb. 9-10.

American Medical Association Annual Meeting, Chicago, June 21-25.

American Association for the Study of Goiter, Toronto, Canada, May 6-8.

American College of Surgeons, Section Meeting, Toledo, Jan. 20-21.

American Urological Association, Boston, May 17-20.

Mahoning County Medical Society, 19th Annual Postgraduate Assembly, Youngstown, April 14.

National Conference on Medical Service, Chicago, Feb. 8.

Northern Tri-State Medical Association, Findlay, April 13.

Rural Health Problems Considered and Policies Adopted At Meetings of Grange and Farm Bureau in Columbus

RURAL health problems occupied the spotlight at Columbus during the month of November, occasioned by the annual meetings of the State and National Granges and of the Ohio Farm Bureau Federation.

Most extensive were the recommendations of the delegate body of the National Grange, which met November 12-21, subsequent to the Ohio State Grange session, November 10-12. The delegates approved in its entirety the report of National Grange's interim Committee on Education and Health, headed by Joseph W. Fichter, Columbus, and in addition reaffirmed its stand on health resolutions passed the preceding year.

ASK CLARIFYING ACTION

Among the new policies as outlined in Fichter's report was the recommendation that the National Grange take some kind of action to clarify "the situation which has resulted virtually in denying the services (of the United States Public Health Service) in assisting them in working out some of their health problems".

It was stated in the report the National Grange agrees with the thesis that public officials should not use their positions to create sentiment for some particular kind of legislation which they might favor. "On the other hand", the statement continued, "we feel that public officials can render a great service to the public by bringing information which they as specialists and technicians have available."

"ALWAYS PROFESSIONAL"

"Furthermore, it is the opinion of the committee that the members of the Public Health Services have always been very professional in the presentation of information, and have not, so far as we know, tried to create sentiment for any type of health legislation."

This stand on the part of the Grange was apparently the result of the failure on the part of the Conference Committee on Rural Health, representing the Grange, Farm Bureau, and the Farmers' Union, cooperating with the Farm Foundation, to obtain the services of the staff of the U.S.P.H.S., for a conference scheduled by this group in the Pacific Northwest last February.

OTHER RECOMMENDATIONS

Other medical and health recommendations of the National Grange were:

1. Enabling legislation in all states for participation in the Federal hospital program.

2. Dissemination of more facts for farm people relating to construction and maintenance problems of hospitals.

3. More farm representation on hospital councils, commissions, or committees.

4. That granges conduct as community projects the establishment of adequate hospital services where they are now inadequate.

5. That state legislatures be requested to match Federal funds for hospital construction and that state funds be made available for partial help in maintaining hospitals in poor communities.

6. That local communities make their needs known to medical, dental, and nursing societies and take steps to induce doctors, dentists, and nurses to come to these areas.

7. That more adequate medical and dental school facilities be provided by colleges that "monopolistic abuse in determination of medical and dental school enrollment prevented", and that medical and dental scholarships be provided to young people wishing to practice in rural areas.

8. Health centers and hospitals in rural areas under the Federal Hospital Survey and Construction Act, and equipping a doctor's or dentist's office by the local community were necessary.

9. That the Grange strongly urge and cooperate in the development of cooperative hospitals and prepaid group hospitalization and medical care plans.

10. Use of Federal, state, and local funds, alone or in combination, to supplement the medical and dental payment of low income families.

11. That when necessary, state legislatures pass legislation to enable the establishment of county, city-county, and multi-county health units which would be large enough to hire full-time personnel.

12. That rural people seek to establish adequate public health services in their communities.

13. Support of legislation to expand Federal and state aid for public health services where necessary.

14. Support of legislation to make laboratory tests and X-rays a public health function.

15. Medical and dental examinations for school children to detect defects and ailments. Schools to provide some medical and dental care for the children, particularly if the parents cannot afford it.

16. State and Federal aid in order to make adequate school health services available to all school children.

17. Increased funds on Federal, state and local levels for medical and dental research.

18. Enactment of enabling laws for health cooperatives and group hospitalization in states where not already in effect.

19. Extension of state and Federal services to health cooperatives.

20. That medical societies be asked to assist in the establishment of sound health cooperatives and in the staffing of such cooperatives.

21. That leaders in existing producer and consumer cooperatives assist in initiating health cooperatives.

22. Urge the various national health agencies to coordinate and integrate their activities and possibly eventually consolidate their drives and activities under one unified voluntary health agency. "A way to start would be to establish a national health fund for those who prefer to continue in the fight against all diseases rather than just one."

PRINCIPLES OUTLINED

The establishment of the following principles was advised concerning health programs and legislation:

1. Every individual should put forth a reasonable effort to meet his own health needs either on an individual or group participation basis.

2. Outlay of public funds should be kept as low as is consistent with the attainment of our objective.

3. Local control and administration should be maintained to the fullest extent feasible.

4. Means tests for those unable to meet the cost of adequate medical care should be avoided if at all possible, and instead a reasonable payment should be required of every individual or family in view of their income status and benefits received.

5. Medical payment plans should be primarily controlled by the consumers or patients.

OHIO STATE GRANGE ACTIONS

The Ohio State Grange passed a resolution favoring the enactment of state laws authorizing the creation of county-wide, city-wide, or multi-county units of health jurisdiction; employment of professional qualified full-time health officers at appropriate salaries; and requirement by law that health departments carry on certain essential standard activities.

PROGRAM OF THE OHIO FARM BUREAU

Meeting November 24-26, in Columbus, the Ohio Farm Bureau Federation asked that:

1. Each county complete a study of health conditions, problems, and facilities, including ways and means of improving local health.

2. County Farm Bureau Committees cooperate with County Tuberculosis and Health Associations to promote the tuberculosis control program.

3. Sufficient funds be provided by the legislature to establish a modern mental hygiene program with adequate facilities and competent personnel for the study, care, and treatment of the mentally ill and mentally deficient.

4. The Farm Bureau give full support to the national program for the prevention and cure of social diseases and urge complete development of the program in Ohio.

5. Federal, state, and local health authorities, in cooperation with professional groups, farm organizations, and others, be urged to take every possible legal, legislative, and professional action necessary to bring rabies under control and to complete eradication.

6. The legislature provide sufficient funds to maintain the permanent basic services of the Department of Health so that the Federal funds may be used as intended, for assistance to local health districts that are economically unable to provide adequate health services.

7. There be a voluntary reorganization of public health districts with a pooling of funds and resources to the end that needless and wasteful duplication may be eliminated and better public health services be provided to people of each area affected, and that the duties of the health commissioner be made mandatory.

8. The legislature appropriate additional funds to make the hospital construction program available for use by the districts. "Then the Farm Bureau should utilize it as a means of helping to develop a building program designed to provide adequate hospital and health clinic facilities for the entire state."

9. The State Department of Education and the State Department of Health be commended for their jointly initiated program of teacher training and certification in health, physical education, recreation and safety, and that each Farm Bureau help promote the introduction of health courses into all rural schools.

10. In recognition of the serious shortage of physicians in rural areas "we recommend that every possible means be taken to relieve this condition".

New Director at Miami Valley

Leslie H. Ringelspach, Dayton, has been elected as director of Miami Valley Hospital, of that city, to replace O. K. Fike, who resigned November 6. Mr. Ringelspach formerly served as associate director for administration. Dr. Harry Wain was reconfirmed as medical director of the institution, a position which he has held since last May.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

MORE, MORE, MORE, ON THE NURSE-SHORTAGE PROBLEM

More on the shortage-of-nurses problem:

From the American Hospital Association comes the announcement that an enrollment of approximately 40,000 new student nurses during the current year is indicated and that the goal for 1948 is 50,000 new nursing students. Physicians are urged to cooperate by encouraging girls to enter the nursing profession.

In *Hygeia*, Dr. Morris Fishbein writes:

"Much discussion has been going on in medical and nursing circles as to the desirability of educating more practical nurses. The excellent work the nurses' aides did during the war has emphasized this possibility. The criticism is made that professional nurses have raised their educational standards and are getting away from bedside nursing. . . . The leaders who are developing this plan assert that nurses of this type will be able to do from 80 to 90 per cent of the ordinary bedside nursing in hospitals. This may be the answer to the major portion of the problem."

Dr. Fishbein's statement was assailed by Ella Best of the American Nurses' Association in a telegram to him, according to a press release from the A.N.A. Wired Miss Best:

"May we respectfully suggest that the solution of the nursing crisis does not lie in the training of more practical nurses to take over the major part of bedside nursing in hospitals, as you were quoted by the Associated Press with a Chicago dateline as saying in *Hygeia*. We recognize that practical nurses fulfill a needed function but not this one. This step would be extremely detrimental and dangerous to a patient's welfare.

"In time of critical shortage of doctors it was not suggested that first-aid technicians be substituted in their place. The same parallel exists between practical and professional nurses.

"The A.N.A. program for practical nurses calls for increased utilization of their services if three precautions are taken: 1—Proper preparation and training of at least nine months in an accredited school. 2—State licensure for practical nurses to maintain standards of practical nursing and to weed out the incompetents. 3—Proper placement and supervision to make certain practical nurses are placed where they will not practice beyond their ability, and to insure their working under competent supervision.

"The American Nurses' Association holds that the crisis in nursing will be overcome only when the profession is made sufficiently desirable to attract and retain a sufficient number of qualified women on a basis of its professional status and economic stability. This rather than lowering the standards of nursing seems to be indicated in the public interest."

It's beginning to look as if everyone is fiddling while Rome burns.

Isn't it about time for those who are sincere

in wanting the problem solved to get together, agree on a program, and then see it through, including legislation, if necessary?

RURAL HEALTH GROUPS NEED YOUR HELP

In our opinion the enthusiasm and determination displayed by representatives of rural health planning groups of 17 counties who attended the Wilmington rural health conference on December 5, as well as their knowledge of the assets and liabilities of the health services in their respective communities, must have made considerable impression on the physicians who attended, at the special request of the Ohio State Medical Association.

Farm folk like those who participated in the Wilmington conference (and there are many more just like them scattered throughout the state) are determined to secure better health protection for their communities. Moreover, they are in favor of having their own communities assume the major responsibilities and obligations, which is a refreshing attitude nowadays.

To suggest that they deserve the support and cooperation of the medical profession in their areas would be too mild a statement. They must have the help of physicians, individually and collectively.

Has your county medical society been asked to meet with them; counsel with them; work with them? If not, why not? Has your society been requested to do so? Has it offered to cooperate?

It's time to get the answers to these questions; then do something about them.

THE JOURNAL UNDERGOES A FACE-LIFTING OPERATION

The Journal decided to celebrate the New Year by having its old face lifted and a new one substituted.

There's a bit of history behind the new format of this issue.

At the A.M.A. Conference of Secretaries and Editors of state medical societies held in Chicago in November, a "clinic" on state medical society journals was held. Experts from some of the outstanding publishing firms of the country diagnosed the good and bad points of some of the state medical magazines—including *The Ohio State Medical Journal*. Incidentally, your Ohio magazine got a high rating which should please you as much as it did those who

work to produce it. But that's aside from the point.

Mr. Robert H. Roy, chief engineer of Waverly Press, talked about cover pages. To emphasize some of his points, he had designed in his shop a format, using *The Ohio State Medical Journal* as the guinea pig, which he felt had a lot of good points. The sample which he displayed appealed so much to the members of the editorial staff of *The Ohio State Medical Journal*, that they decided to "steal" the design.

Thus, *The Journal*, thanks to Mr. Roy, has a new face. We hope you'll like it. At any rate, you ought to be able to find it quickly in that stack of magazines which is on the far corner of your desk—unless, of course, you're color blind.

HAVE YOU BEEN FILING PERSONAL PROPERTY TAX RETURN?

State Tax Commissioner Glander in a recent report to the Governor announced a vigorous drive to collect past due personal property taxes, pointing out that at present his department is adding personal property taxes at the rate of \$30,000 per week and new taxpayers at the rate of 750 per week. Obviously, penalties are being assessed against those who have been delinquent or have failed to declare personal property for taxation.

This is a matter of direct concern to all physicians—at least most all of them—as it is assumed all physicians in practice maintain an office.

Under the law, all persons engaged in business are required to file a personal property tax return which includes the listing of all intangibles and tangible personal property used in business, such as furniture, fixtures, equipment, supplies, etc.

The State Tax Department has intimated that more than a few physicians have not been filing such a return and paying such a tax. Doubtless, they have a lot of company. But that doesn't excuse them nor minimize the risk they have been taking.

Better check on this. A crack-down on offenders is under way.

PUBLIC RELATIONS MINUS BRASS BANDS AND RED FLARES

Did you ever stop to think that it doesn't take brass bands, Hollywood bathing beauties, full-page newspaper ads, and radio whiz-bangs to create good public relations?

To prove the statement, here are two examples of how two medical societies won a lot of good will without fanfare or red flares.

Last Summer a group of members of the Summit County Medical Society cooperated with Boy Scout officials in conducting a medical re-check

program at the camp of the Akron Area Scouts. In a recent issue of the *Summit County Medical Society Bulletin* appeared a letter from the area scout executive thanking the individual physicians and the medical society for their assistance, pointing out that a communication had been sent to the national organization calling attention to the "fine cooperation Scouting receives here in the Akron Area".

Up in Lake County, the medical society voted to raise \$1,500 among its members to establish an infirmary for the Girl Scout Camp. The local newspapers complimented the society, pointing out that the Lake County Medical Society by its action has transformed into concrete action one of the points of the 25-point health program of the Ohio State Medical Association—improved recreational activities for young and old.

Believe it or not but it is the series of comparatively little things done frequently by the medical profession, especially in an organized fashion, which pays real dividends in the winning of public good will and recognition.

VALUABLE REPORT ON STREPTOMYCIN PUBLISHED

If you haven't read it, get and review carefully the special report of The Council on Pharmacy and Chemistry of the American Medical Association on streptomycin, published in the November 29 issue of *The Journal of the A.M.A.*

As the Council points out it is difficult to classify the nuances of experience with this drug of recent development. It adds, however, that the data presented afford a fair estimate, for the present, of desirable, balanced against undesirable effects.

Don't take a chance. Inform yourself. Keep up to date.

UNCLE SAM: SANTA CLAUS OR HORSE TRADER?

Judging from reports on the recent conference of state and territorial health officers in Washington, Federal planners want to subsidize medical students "to increase the supply of physicians".

As a pay-off, such students would be expected to serve some time after graduation in the public health service or in areas deficient in physicians, it is said.

Maybe we're a bit thick but the idea appears to be cockeyed.

Is there a shortage of applicants for medical schools? We haven't heard of it. This would seem to indicate that the lack of finances is not a very important factor, if a factor at all.

Are medical schools able to admit all qualified applicants? No, because they don't have

adequate facilities and personnel to properly train a greater number than is now enrolled.

Can new medical schools, offering adequate instruction, be created overnight? Obviously they can not.

How many students would be willing to pledge themselves for government service? We're not sure too many will want to put up that kind of a bond.

Will physicians "assigned" to deficiency areas be able to practice good medicine and win the esteem of the community? Some might find this to their liking but the failures would be in the majority, in our opinion.

Subsidizing medical students won't solve the problem. Building of more good medical schools, without strings attached, might.

HELP FIND THE MISSING CASES, DOCTOR!

The keynote of 1948 Social Hygiene Day on February 4, will be "Find the Missing Million and Help Stamp Out V.D.", according to the American Social Hygiene Association, which annually sponsors the observance from coast to coast during the first week in February.

The theme, which derives from the fact that close to a million cases of infectious V.D. each year fail to come to treatment, offers a special opportunity for physicians and medical societies to help enlist their communities in activities against the venereal diseases, says Chas. Walter Clarke, M.D., Association Executive Director.

In addition to stressing case-finding, observances will also emphasize stronger efforts to prevent infection, Dr. Clarke added.

Medical societies should give their support and backing where preparations for Social Hygiene Day meetings are already under way. Better yet, they might take the initiative in organizing observances where they are not yet planned.

FORGET THE OLD LABELS; GET IN AND PITCH

Of more than passing interest is the statement issued by Dr. Harold J. Knapp, health commissioner of Cleveland, at the time of the annual round-table conference of the American Public Welfare Conference held in Cleveland, recently.

Said Dr. Knapp: "The present trend in public health is towards a closer relationship between public health and public welfare endeavors in the development of adequate programs, especially in the field of medical care. The delimitation of boundaries between public health and public welfare is often indefinite. Suffice it to say, there is a close parallelism between economics and health."

As Dr. Knapp infers, public health cannot be set aside from the over-all social welfare

needs and activities of a community. For this reason, the medical profession must be concerned and actively interested in all of the welfare programs of the state and local areas. Workers in public welfare need the guidance of physicians who dare not shirk their responsibility by resorting to aloofness or by falling back on the old excuse that all things labeled "welfare" are bad, so must be opposed. Those days have gone. Today the medical profession has an important role to play in all activities of widespread community interest. Seeing that this is done is one of the obligations of local and state medical societies.

GET WORKMEN'S COMPENSATION FORMS IN PROMPTLY

Officials of the State Industrial Commission state that some physicians are becoming exceedingly lax in the filing of claim blanks, reports, and fee bills within the time limits specified in the rules of the Commission.

There are several important reasons why physicians should get these documents into the offices of the Commission promptly:

First, delay works to the disadvantage of injured claimants.

Second, the work of the Commission in adjudicating claims is slowed up.

Third, if the delay extends beyond two years, the claim may be outlawed by the statute of limitations.

Fourth, if the above should happen, both claimant and physician will lose any chance of receiving payment.

Fifth, if a claim is outlawed because the physician is at fault, the physician might be charged with negligence and be made the defendant in a suit for damages.

Sixth, the physician can't be paid until all required forms are on file, including his fee bill.

A PIECE ABOUT "SECOND CLASS PATIENTS"

Chet Lampson of *The Jefferson Gazette*, who has been an old friend of The Editor for lo these many years, sat himself down recently and wrote an editorial which he published in the December 2 issue of his paper under the heading "Second Class Patients!"

It didn't take Chet long to get to the point. Because he reveals in so few words what he terms "the beauties of compulsory health insurance", we are taking the liberty of passing on to our readers the entire piece, which, bear in mind, was written through the specs of a layman—not a doctor:

SECOND CLASS PATIENTS!

"The beauties of compulsory health insurance were recently illustrated in a large western

city which has that kind of a system in effect for municipal employees.

"The director of the system sent a letter to all doctors associated with it, pleading that it is in financial difficulties, and making three remarkable requests.

"First, he asked that doctors restrict the use of laboratory tests, X-ray examinations and normal diagnostic procedures, and substitute 'routine examinations' for careful, scientific diagnoses.

"Second, he asked that they discourage patients with 'minor ailments' from seeking professional medical treatment, and advise them to use home remedies.

"Third, he ordered that hospitalization be denied to system members except in the most critical cases, and except on specific authorization by himself.

"The executive committee of the local county medical society answered this by observing that 'neither your doctor nor any reputable doctor can, in clear conscience, agree to a demand that city employees be denied adequate medical care and that they be treated as "second class patients"! That answer covers the ground completely. The logical result of any other policy would be what has happened under socialized medicine in England, where overworked doctors must deal with excessive numbers of patients and only the few can be given really individual attention and diagnosis.

"Compulsory health insurance on a national scale would be a reflection of the condition in the western city multiplied a thousand times. When politics take over medicine, the standards of medical care inevitably decline."

TIME TO GET READY FOR THE 1948 SWEEPSTAKES

Fred W. Perkins, Scripps-Howard writer in Washington, says the American Federation of Labor is organizing a political action league "to drive out of Congress all members who voted for the Taft-Hartley law".

According to Perkins, "emphasis will be on registration of union members and their families and on getting them to the polls next November".

Have you been thinking about next year—an election year, Doctor?

You should. The medical profession has a big stake also in the outcome of the 1948 November election. What are you going to do about getting members of your family and your friends and neighbors—perhaps patients—to the polls? What are you going to do about passing on important information about candidates to them?

A good time to start work would be prior to the primary elections next Spring when candi-

dates will be selected by the parties for the November election.

Those with an interest in the 1948 sweepstakes should not be caught napping at the get-away.

CARRY A PAD OF DEATH CERTIFICATES WITH YOU

Ohio law requires that a burial permit may not be issued until a satisfactory certificate of death has been presented to the local registrar of vital statistics and that cemetery officials may not allow a burial to be made unless a burial permit is presented.

Some local registrars, funeral directors, and cemetery officials are complaining that they are being seriously handicapped in their work because of the slowness on the part of some physicians in filling out death certificates.

It is hoped that all physicians will cooperate fully with these three groups.

For convenience in filling out certificates, why not get a pad of death certificate forms from your local registrar and carry it with you? If you have blanks handy, you can fill out the medical section of the form when death occurs and leave the form readily available for the funeral director.

IT PAYS FOR BOTH DOCTOR AND PATIENT TO BE FRANK

"If the relations between the public and its friends, the doctors, are to improve—as they must—we advise both parties to the medical contract they enter into to be a little more frank with each other," editorializes the *New York State Medical Journal*.

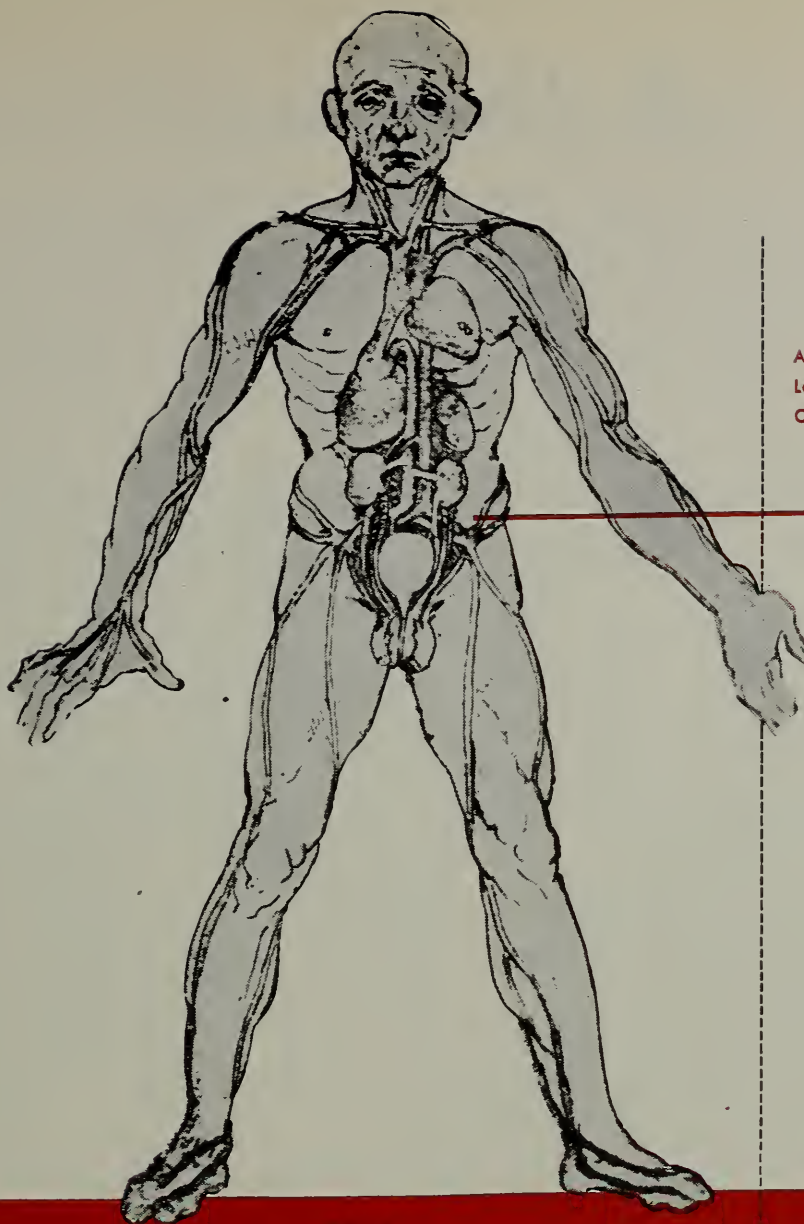
To this we say amen. It is well known that not enough physicians take the time to sit down with certain patients and have a heart-to-heart talk with them about the medical and economic aspects of the case.

On the other hand, not enough patients put the cards on the table for the information and benefit of the physician—so he can handle the case accordingly.

This lack of frankness between a physician and patient often causes misunderstandings which could just as well have been avoided.

Gastro-Enterology Award

A prize of one hundred dollars and a certificate of merit will again be awarded in 1948 by the National Gastro-Enterological Association for the best unpublished contribution on gastro-enterology or allied subjects. Limited to 5,000 words, entries must be filed with the Association, 1819 Broadway, New York 23, not later than April 1.



Anatomic drawing by
Leonardo da Vinci—
Courtesy, The Bettmann Archive.

Leonardo da Vinci (1452-1519)

was well ahead of his time, for physicians of his day knew little of the function of the heart or the treatment of its diseases, although da Vinci's knowledge of such anatomy was extensive.

Physicians of today prescribe

SEARLE **AMINOPHYLLIN***

—a modern treatment for congestive heart failure, bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration.

Supplied for oral, parenteral and rectal use.

G. D. Searle & Co., Chicago 80, Illinois.

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.



SEARLE

RESEARCH
IN THE SERVICE
OF MEDICINE

In Memoriam

Oscar Arthur Axelson, M.D., Youngstown; University of Michigan Medical School, 1930; aged 44; died Dec. 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Axelson had been a practicing physician in Youngstown from 1932, until he entered the U.S. Army Medical Corps in July, 1942. Serving as a captain, he went overseas in September, 1943, he was in Normandy a few days after D-Day and participated with the Third Armored Force in numerous battles in France, Belgium, and Germany. He was awarded the Bronze Star for meritorious service, a Presidential Unit Citation, and five campaign stars. Following his discharge from the service he re-entered practice at Youngstown. He was a trustee of the Covenant Church, and a member of the Masonic Lodge. His widow, a daughter, and a son survive.

Charles W. Banks, M.D., Hartford; Cleveland-Pulte Medical College, 1899; aged 75; died Dec. 8. Dr. Banks had practiced in Trumbull County for 41 years until his retirement a year ago. He belonged to the Presbyterian Church and was a 48-year member of the Masonic Lodge. His widow and two daughters survive.

Grace Mott Boswell, M.D., Cincinnati; Miami Medical College, Cincinnati, 1909; aged 77; died Nov. 7; former member of the Ohio State Medical Association and the American Medical Association. Dr. Boswell had practiced medicine in Cincinnati for 40 years. Two sisters and a brother survive.

John Blayne Claypool, M.D., Niles; Hahnemann Medical College and Hospital of Philadelphia, 1893; aged 78; died Dec. 5; former member of the Ohio State Medical Association and the American Medical Association. Dr. Claypool had practiced medicine in Niles for over 50 years and was vice-president of the Trumbull County Medical Society in 1919. A brother survives.

Hervey John Smith Dickson, M.D., Springfield; Medical College of Ohio, Cincinnati, 1891; aged 86; died Nov. 17; former member of the Ohio State Medical Association and the American Medical Association. Dr. Dickson was health commissioner of Champaign County for four years prior to 1924 when he moved to Springfield, where he practiced until his retirement in 1943. He had practiced medicine in Mechanicsburg for 17 years before assuming his duties as health commissioner. He was a member of the Masonic Lodge and the Presbyterian Church. His widow survives.

Harry Lawrence Farmer, M.D., Cleveland; Baylor University College of Medicine, Dallas,

1918; aged 52; died Dec. 6; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Radiology; diplomate of the American Board of Radiology; and member of the American Roentgen Ray Society and the Radiological Society of North America. He was a member of the board of directors of the Christian Church. His widow, two sons, and a daughter survive.

Edwin F. Landy, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1891; aged 79; died Nov. 21. Dr. Landy practiced medicine in Cincinnati for more than 50 years prior to his retirement five years ago. He was assistant professor of internal medicine at the Medical College of Cincinnati from 1894 to 1897 and was a veteran of the Spanish-American War. While attending Yale University he was a member of the track team of 1888 which won the intercollegiate cup in that sport for the first time in the history of the school. He was a member of the Yale Club, Sons of the American Revolution, and the Historical and Philosophical Society of Ohio. His widow and a daughter survive.

Daniel W. Lowe, M.D., Woodsfield; Starling Medical College, Columbus, 1903; aged 72; died Dec. 2; member of the Ohio State Medical Association and the American Medical Association. Dr. Lowe had practiced medicine in Monroe County since 1914 and was a member of the Catholic Church. His widow, a son, and a brother survive.

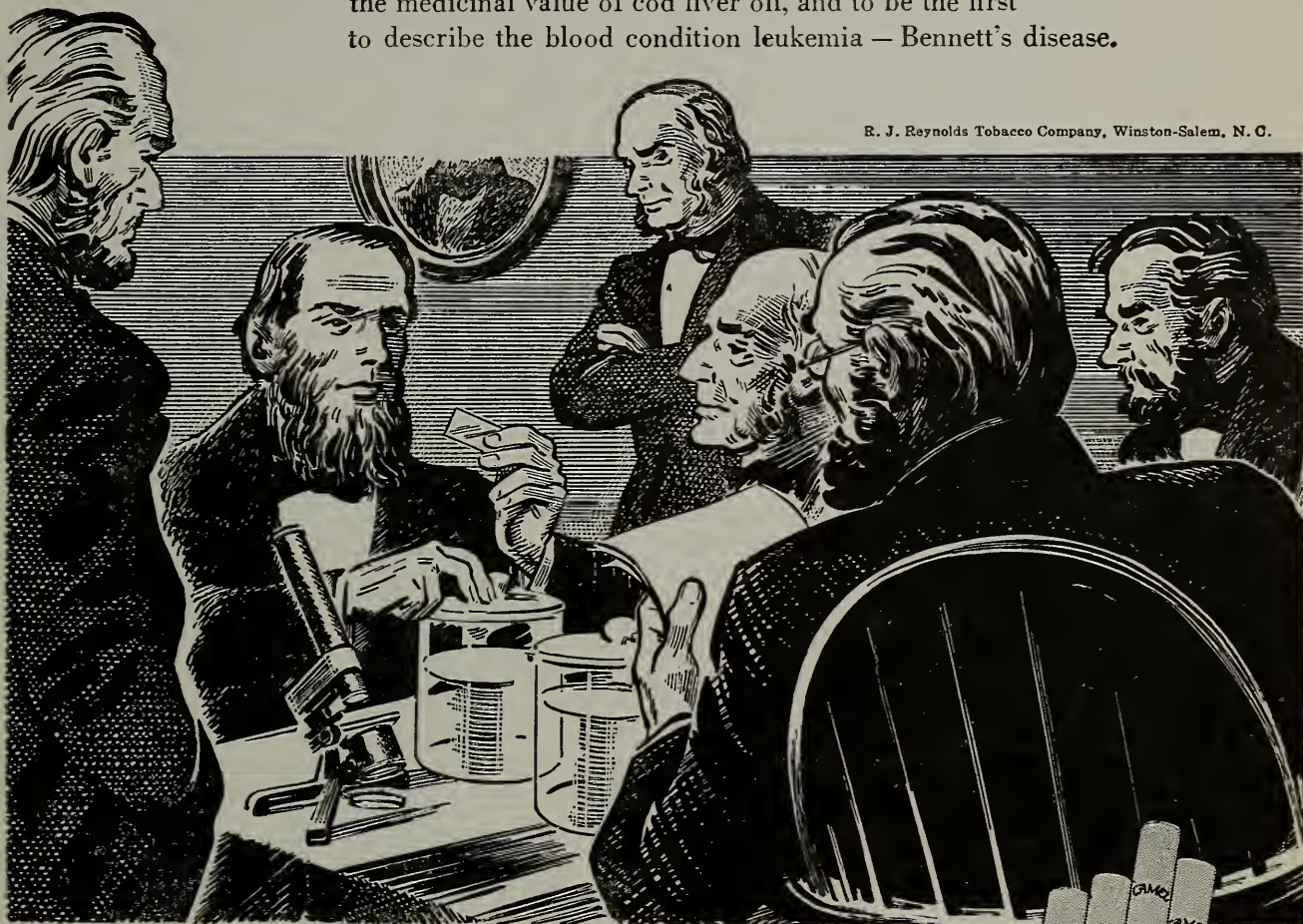
Thurman Francis McAllister, M.D., Coshocton; Ohio State University College of Medicine, 1934; aged 38; died Nov. 11; member of the Ohio State Medical Association and the American Medical Association. Dr. McAllister was president of the Coshocton County Medical Society in 1939 and 1940. During World War II he served for three years in the U.S. Army Medical Corps, 18 months of which were overseas. He had practiced medicine in Coshocton since 1938. A member-elect of the city school board, Dr. McAllister was a member of the Methodist Church, Masonic Lodge, Rotary Club, and the American Legion. Surviving are his widow, his mother, two daughters, a brother, and two sisters.

Charles Allen McDonald, M.D., Columbus; Chicago College of Medicine and Surgery, 1913; aged 62; died Nov. 23; member of the Ohio State Medical Association and Fellow of the American Medical Association. A former assistant medical examiner for the Pennsylvania Railroad, Dr. McDonald had retired 17 years ago after 17 years in the practice of medicine. During World War I he served as an officer in the U.S. Army Medical

Experience is the Best Teacher

JOHN HUGHES BENNETT (1812-1875) proved it in histology

Bennett's experiences, gained by linking physiology with clinical medicine, led him to institute the practical study of histology, to recognize the medicinal value of cod liver oil, and to be the first to describe the blood condition leukemia — Bennett's disease.



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

Yes! And experience is the best teacher in smoking, too!



DURING the wartime cigarette shortage, people smoked many different brands—any brand they could get. And as they smoked—they naturally compared the different brands... for taste, for mildness, for coolness... for all-round smoking enjoyment. More and more smokers found from the experience of those comparisons that Camels suit them best.

Result? *More people are smoking Camels than ever before!*

According to a Nationwide survey:



More Doctors Smoke CAMELS than any other cigarette

Three nationally known independent research organizations asked 113,597 doctors — in every branch of medicine — to name the cigarette they smoked. *More doctors named Camel than any other brand.*

Corps, and during World War II he served for a time as industrial physician at the Curtiss-Wright Corporation plant in Columbus. He was a member of the Masonic Lodge and the American Legion. Surviving are his widow, a sister, and two brothers.

Charles C. Meade, M.D., Cincinnati; Pulte Medical College, Cincinnati, 1890; aged 85; died Nov. 7. Dr. Meade was a practicing physician in Cincinnati for 42 years, was a former president of the Hamilton County Fair Board, and was for a number of years engaged in the raising of trotting and pacing horses. His widow and two sons survive.

Gertrude Kirkpatric Meck, Cleveland; Cleveland Pulte Medical College, 1910; aged 80; died Nov. 9. The widow of David C. Meck, Sr., former dean of John Marshall Law School in Cleveland, Dr. Meck had practiced medicine in Cleveland until her retirement 20 years ago. She was a member of the First Unitarian Church. Surviving are a daughter, and two sons, including Dr. Floyd S. Meck of Cleveland.

George Clifton Rodebaugh, M.D., Pasadena, Calif.; Ohio State University College of Medicine, 1912; aged 61; died Nov. 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Rodebaugh had practiced medicine in Springfield from 1910 until moving to Pasadena last April. He served in the U.S. Army Medical Corps during World War I. Surviving are his widow, two daughters, his mother, and a sister.

Horace Adam Skidmore, M.D., West Mansfield; Starling Medical College, Columbus, 1902; aged 73; died Nov. 18; former member of the Ohio State Medical Association and the American Medical Association. Dr. Skidmore had practiced medicine in Logan County for about 45 years. His widow survives.

Jay Dickey Smith, M.D., Akron; Starling Medical College, Columbus, 1906; aged 68; died Nov. 17; member of the Ohio State Medical Association; Fellow of the American Medical Association and of the American College of Surgeons. Dr. Smith was delegate to the Ohio State Medical Association from 1922 through 1928, and was president of the Summit County Medical Society in 1935. Engaged in the practice of medicine in Akron since 1913, he was a member of the Masonic Lodge, Knights Templar, and the Rotary Club, and a director of the Akron City Club. A memorial fund for People's Hospital Library in Akron will be established in his name. His widow, a daughter, three brothers, and a sister survive.

James Charles Sommer, M.D., Grove City; Ohio State University College of Medicine, 1913;

aged 63; died Nov. 21; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Sommer was president of the Perry County Medical Society in 1921, when he was engaged in the practice of medicine at Somerset. He moved to Grove City in 1923 and became president of the First National Bank of that city, and served 15 years as president of the Jackson Township Board of Education. Dr. Sommer was serving his fourth term as a member of the Franklin County Board of Education, and was a member of the Methodist Church and the Masonic Lodge. Surviving are his widow, a daughter, and four sons.

Erwin Straehley, Sr., M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1889; aged 79; died Nov. 6; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Straehley entered the practice of medicine in Cincinnati in 1891 and had served for over 50 years on the staffs of Christ and Deaconess Hospitals there. From 1915 to 1932 he was a trustee of the University of Cincinnati and for a number of years had served as medical examiner for several insurance companies. While in medical school he won a gold scholastic medal and two professional awards. Dr. Straehley was a 50-year member of the Masonic Lodge. Surviving are two sons, Dr. Erwin Straehley, Jr., and Dr. Clifford Straehley of Cincinnati, a sister, a brother, and five grandchildren, including Dr. Clifford Straehley, Jr., a resident physician at Massachusetts General Hospital, Boston.

Perry Irwin Tussing, M.D., Lima; Rush Medical College, University of Chicago, 1906; aged 80; died Nov. 26; former member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Tussing was treasurer of the Allen County Academy of Medicine in 1921 and 1923, and was president in 1926. He had practiced medicine in Lima for 37 years prior to his retirement four years ago. Previous to entering medical school he was a chemistry professor at Ohio Northern University at Ada. His widow survives.

Rome Maynard Webster, M.D., Dayton; Hahnemann Medical College and Hospital of Philadelphia, 1907; aged 64; died Nov. 25; member of the Ohio State Medical Association and the American Medical Association. A native of Dayton, Dr. Webster had practiced medicine there for 40 years. Dr. Webster's grandfather, his father, and his uncle, were all members of the medical profession, and a brother, Dr. Howard H. Webster, is in practice at Dayton. He was a member of St. John's Lutheran Church. Surviving are his widow, a daughter, his brother, and a sister.

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Examinations for License in Ohio Taken By 22 Medical School Graduates; List of Questions Asked By Board

LICENSES to practice medicine and surgery in Ohio were sought by 22 medical school graduates at the examinations of the State Medical Board, held in Columbus, December 2-4.

Six applicants were examined in osteopathic medicine and surgery. In addition, three osteopaths, previously licensed in Ohio, sought licensure in osteopathic medicine and surgery, and six were examined for endorsement of license.

Examinations for certificate of limited practice were taken by 20 chiropractors, 35 mechanotherapists, 3 chiropodists, 12 cosmetic therapists, and 56 masseurs.

Results of the examinations will be announced by the Board at a meeting to be held in Columbus, January 6.

Following are the written questions asked those who were examined for licenses to practice medicine and surgery:

ANATOMY

1. Outline the venous drainage of the skull and brain.
2. Describe the anatomy of the tonsils.
3. Give histology of the kidneys.
4. Outline the muscles of the eye and give nerve supply and action.
5. Describe the biliary system and ducts.

PHYSIOLOGY

1. Define: (a) oliguria; (b) myopia; (c) ischemia; (d) plethora; (e) myasthenia gravis.
2. What are the functions of: (a) kidney glomeruli; (b) cerebrospinal fluid; (c) thrombin?
3. Discuss the part played by the pancreas in digestion.
4. What is meant by "mass reflexes"? By "temporal summation"?
5. What is hyperpnea and what is its physiological significance?
6. What is visual accommodation and how accomplished?
7. What is the importance of water balance in the system and how is it maintained?
8. What is hypoglycemia and what are its effects physiologically?
9. Discuss the elimination of acids and bases by the kidney.
10. Give the factors effecting peripheral vaso-dilation.

BACTERIOLOGY

1. Describe the tetanus bacillus. How does it usually gain entrance into an individual and what prophylactic measures should be employed in such trauma?
2. Describe the cause of Rocky Mountain Fever. How is it conveyed to man and give the laboratory diagnosis.
3. Describe the organism of actinomyces. How does it gain entrance into man and how may it be detected?
4. What is meant by hypersensitiveness to (a) a pollen; (b) a drug; and (c) a food? How would you detect the offending agent?
5. Name and give the morphologic and cultural characteristics of the infective agent of brucellosis. Name the three domestic animals which may be the source of human infection.

DIAGNOSIS

1. Differentiate by blood, urine and physical examination: (a) chronic glomerular nephritis; (b) essential hypertension; and (c) chronic nephrosis.
2. Differentiate hematogenous, hepatogenous and extra hepatic jaundice.
3. Give cause of death in sub-acute bacterial endocarditis; thyrotoxic goitre; and obstructed blood flow in circle of Willis.
4. Name the different diabetes and blood findings and urine findings in each.
5. Differentiate diagnosis of undulant fever, tularemia and trichinosis.
6. Give clinical and microscopical findings in nasal diphtheria, Vincent's angina, and non-specific stomatitis.

7. Give blood findings in the chronic leukemias.
8. What methods would you employ to differentiate brachial neuritis and coronary occlusion?
9. Differentiate cardio spasm and malignancy of lower third of esophagus.
10. Define chronic hypertrophic arthritis, rheumatoid arthritis, and arthritis deformans.

MATERIA MEDICA AND THERAPEUTICS

1. (a) Define isotope. (b) What is meant by "it's half life"?
2. Name five manifestations of systemic toxicity to D.D.T.
3. Name the essential amino-acids necessary to establish nitrogen balance in starvation.
4. Patient presents the following blood findings:

Hemoglobin	7.5 grams
R.B.C.	3,100,000 per cm
W.B.C.	5,000 per cm
Platelets	280,000 per cm
Hematocrit	22 normal 45
Reticulocytes	0.5%

(a) Give drug of choice in this type of anemia.
(b) Dosage.
5. Name three conditions in which transfusion of whole blood is superior to plasma.
6. Outline the treatment of Phlebothrombosis.
7. Give the therapeutic measures you would employ, the mechanism of their action in paroxysmal nocturnal dyspnea.
8. State the symptoms of poisoning by benzedrine sulfate. Indicate the treatment.
9. Indicate the difference in the action of prostigmin and physostigmin.
10. Discuss the changes in the hyperplastic thyroid gland following the use of propyl thiouracil.

CHEMISTRY

1. Discuss the significance of bile in the urine. Give a method of testing for its presence.
2. What is the normal number of eosinophiles (normal range) for each cubic millimeter of blood? What is the significance of eosinophilia?
3. What is the permanganate or organic index of cerebrospinal fluid?
4. What is hemoglobinemia? What is its manifestation?
5. Discuss amino acids and their importance in body chemistry.

PRACTICE

1. Name eight clinical features which classify chronic organic diarrhea as serious.
2. Give the etiology, symptoms and complications of undulant fever.
3. (a) Give two causes of dyspnea.
(b) Give two causes of cyanosis.
4. Give the etiology and complications of malaria.
5. Give the complications of diabetes mellitus.

PATHOLOGY

1. Discuss the different pathologic findings in lobar and virus pneumonias.
2. Discuss the findings at autopsy in carcinoma of the lung.
3. What pathologic findings may be found at autopsy in a case of bacterial endocarditis in (a) the heart and (b) in other organs.
4. Name three causes of enlarged spleen and give the pathologic findings in each.
5. Give three causes of massive vomited blood. Describe briefly the probable pathology present in each.
6. What is the usual pathology present in gangrene of the lower extremities in a diabetic patient.
7. What is the cause and resulting tissue changes in (a) silicosis and (b) anthracosis? How should such dangers be guarded against?
8. Define intestinal intussusception and discuss the pathology that may result.
9. What is meant by the term hypertrophy? Give an illustration of a hypertrophied organ and how it is produced.
10. Name three diseases resulting from vitamin deficiency and give the vitamin lacking in each.

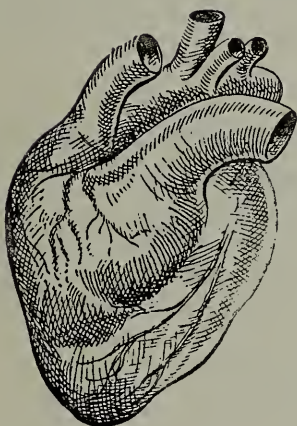
SURGERY

1. Describe the progress of an infection of a flexor tendon of the thumb and discuss its surgical management.
2. What principles underlie the treatment of gunshot wounds of the abdomen?
3. A patient is brought into the hospital with a severe

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ABSORPTION of Purodigin is virtually complete. Almost no irritating residue is left in the digestive tract.

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compound comminuted fracture of the middle third of the humerus.

- (a) Enumerate the diagnostic procedures indicated to arrive at a complete diagnosis (omitting explanations).
- (b) Indicate briefly the principles of the management of this case.
4. Give the common causes of ischiorectal abscess. Discuss its treatment, possible sequelae and their treatment. (Omit details of operative technic.)
5. Give the probable clinical history, the differential diagnosis, and indicate the surgical management of carcinoma of the ampulla of Vater. (Omit operative technic.)

OBSTETRICS AND GYNECOLOGY

1. What is phlebitis? Give cause and treatment.
2. Describe the types of version.
3. Give cause, symptoms and treatment of rupture of the uterus.
4. Give causes, signs and treatment of fetal asphyxia.
5. How would you manage a breech presentation? Face presentation?

SPECIALTIES

1. Describe the skin manifestations and give treatment for cerebrospinal meningitis.
2. Give the cause, symptoms and treatment of diphtheria.
3. Define the following: blepharitis; chalazion; dacryocystitis; and Ludwig's angina.
4. How are the following diseases transmitted: trichinosis; trachoma; psittacosis; and tularemia.
5. Describe an epidemic of poliomyelitis, giving incubation period, types of paralysis, prognosis and treatment.

PREVENTIVE MEDICINE AND HYGIENE

1. What is the period of incubation and what is the period of communicability of:
 - (a) diphtheria
 - (b) pertussis
 - (c) typhoid
 - (d) syphilis
 - (e) measles
2. Give an adequate program for control and eradication of rabies. Give means of communication of the disease.
3. Discuss Vincent's angina, giving cause (etiology), characteristic diagnostic points, means of communication and methods of prevention and eradication.
4. Outline an adequate inspection program for public food dispensaries.
5. Give etiology, means of communication and method of control of yaws.

Essay Contest Announced

The American Urological Association offers an annual award of \$1,000 (first prize \$500, second prize \$300, and third prize \$200) for essays on the result of clinical or laboratory research in urology. Competition is limited to urologists who have been in practice for not more than five years and to residents in urology in recognized hospitals. The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, May 17-20, 1948. Essays must be in the hands of Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tenn., before March 1, 1948.

The United States Office of Education has announced that there are 2,338,226 students presently enrolled in the universities and colleges of the United States. This is a 12½ per cent increase over the unprecedented enrollment of a year ago. The total enrollment is 1,000,000 more than the prewar peak reached in 1940. Ohio ranks fifth among the states in total enrollment, with 142,279.

Buckeye News Notes

Akron—Speaking before the Exchange Club of this city recently, Dr. C. F. Wharton assailed the Wagner-Murray-Dingell bill as a "sugar-coated monstrosity that will saddle needless expense upon the people of the United States".

Apple Creek—Formerly staff psychiatrist at the State Bureau of Juvenile Research, Dr. James W. McGough has been named superintendent of the Apple Creek State School for the Mentally Deficient. He succeeds Dr. E. F. Clouse who retired October 1.

Bluffton—Dr. F. D. Rodabaugh, who was stationed in the Far East as a medical officer during World War II, has received a citation from the Chinese National Government awarding him the Special Breast Order of Yun Hui with Ribbon for "meritorious and outstanding services which aided China in the prosecution of the war against Japan".

Canton—Dr. O. G. Wilson has been appointed a trustee of Molly Stark Sanatorium.

Cincinnati—Dr. David H. Ross, assistant director of Mt. Sinai Hospital, New York City, has been named superintendent of Jewish Hospital, to succeed Van C. Adams, who resigned effective Dec. 1.

Columbus—The Columbus Hospital Federation is sponsoring a public subscription campaign to raise at least \$6,000,000 to finance construction which will provide seven Columbus hospitals with 632 additional beds.

Crestline—"Oriental Children and Their Diseases", was the topic discussed by Dr. M. H. Vinkel at a meeting of the Child Conservation League. Dr. Vinkel spent many years in China before and during the war.

Cuyahoga Falls—"Science of the Brain Waves" was the subject discussed by Dr. L. M. Weinberger, Akron, at a meeting of the Kiwanis Club.

Eaton—A private pilot since 1944, Dr. J. R. Williams recently qualified as a flight instructor. During the war he was a captain in the Medical Corps of the A. A. F.

Grove City—Dr. E. B. Junkermann, Columbus, gave an illustrated address on "The Social and Political Problems of India", at a meeting in the Methodist Church. Dr. Junkermann was stationed in India for eight months while an officer in the U.S. Army Medical Corps.

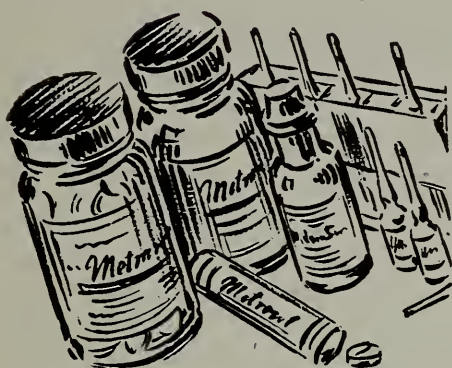
Jefferson—Dr. Charles C. Crosby, Saybrook, has resigned as health commissioner of Ashtabula County. He had held the post since Sept. 30, 1940. Previously, Dr. Crosby was in private practice in Ashtabula for 32 years.

Kent—Dr. Elizabeth Leggett, physician for the Kent State University football squad since 1935, has missed only one team game in 12 years.

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AMPULES - 1 and 3 cc. (each cc. contains $1\frac{1}{2}$ grains.)

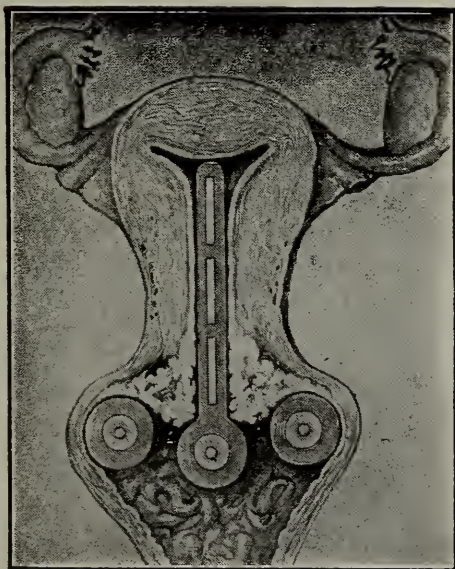
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ORAL SOLUTION - (10% aqueous solution.)

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Lima—Dr. Alfred W. Pinkerton spoke on "Diseases of Children" at a public meeting in Defiance sponsored by the Defiance County Tuberculosis and Health Association.

Marion—Dr. Daniel M. Murphy spoke on "Communicable and Contagious Diseases in Industry; Causes and Prevention", at a meeting of the Industrial Safety Council.

Medina—Dr. H. P. H. Robinson has retired as health commissioner of Medina County. His temporary successor is Dr. William Dwyer, Medina, formerly of Cleveland.

Millersburg—Dr. R. K. Ramsayer, Canton, was guest speaker at a meeting of the Rotary Club. He showed pictures of historical importance of the Santa Fe region of New Mexico.

General Assembly Enacts 12 Bills; Provides Hospital Survey Funds

In a session lasting slightly over 28 hours, the Ohio General Assembly, meeting in special session December 3 and 4, enacted all 12 of the administration-recommended measures presented to it for action.

Of interest from the medical and health standpoint was the appropriation of \$33,200 to the Ohio Department of Health to be used for the Ohio Hospital Survey, in connection with the Hill-Burton Hospital construction program during 1948. Funds for this purpose were provided for only the first half of the biennium during the regular session of the assembly early in 1947.

A total of \$3,075,000 was appropriated to the Department of Public Welfare for poor relief. This expenditure is for the biennium and will cover matching funds necessary to carry the costs incurred in providing for hospitalization under the poor relief law. The inclusion of hospitalization in the definition of poor relief was the result of an act passed in the regular session.

Also approved was a temporary law which will reduce the required majority vote on special levies for operating and welfare purposes at primary and general elections from 65 to 60 per cent. This act will remain in force until December 31, 1948.

The one-cent a gallon liquid fuel tax was removed from the books, but to make up for the loss in revenue, another cent was added to the three-cent a gallon gasoline tax. The uniform \$10 auto license tax law was clarified so that it will be effective March 1. Political subdivisions were authorized to convey land to the Federal Government for Veterans' Administration hospital sites.

William Helmer, Cincinnati, has been reappointed to membership on the Ohio Public Health Council by Governor Thomas J. Herbert. His term will end July 1, 1954.

GIVE NAMES OF ASSISTING DOCTORS ON W. C. BLANK

Failure of the attending physician or surgeon to list the names of assistants, anesthesiologist, or roentgenologist in reporting Workmen's Compensation cases is the cause for an increasing number of cases of unnecessary delay in payment for these services, according to the Claims Section of the State Industrial Commission.

When the attending physician or surgeon files a claim, he should list on the blank the names of all other physicians who rendered service to the claimant. When the blank is received by the Industrial Commission, it is immediately given a number, and blanks for fee bills, with the number of the claim and the name of the claimant, are sent to all physicians whose names appear on the attending physician's report and who aided him on the case.

Michigan P-G Institute, March 10-12

The Second Annual Michigan Postgraduate Clinical Institute will be held at the Book-Cadillac Hotel, Detroit, March 10-12. Forty-nine clinicians and lecturers will present a concentrated three-day postgraduate course in the fields of medicine, surgery, obstetrics, pediatrics, dermatology, ophthalmology, otolaryngology, and general practice.

Two evening sessions will be held, one presentation being a "question box" and the other being a panel discussion on "First Aid to the Acutely Injured Patient". All members of the American Medical Association are cordially invited to attend the institute, and there will be no registration fee.

Want Doctors For Okinawa Project

Two doctors of medicine are needed by the Atkinson-Jones Construction Company of Sausalito, California, for the establishment of a medical department in connection with the construction of U. S. Army installations on Okinawa.

One of these doctors, who must be between the ages of 40 and 49 years, would receive a salary of \$175 per week, and would serve as head of the department. The other, a younger man, would act as his assistant with a salary of from \$150 to \$160 per week, depending on his experience.

Applicants may write to Dr. B. C. Hamilton, Aetna Casualty and Surety Company, 111 Fulton Street, New York 7.

Do You Know? . . .

Dr. Clyde L. Cummer, Cleveland, former president of the Ohio State Medical Association and ex-chairman of the Committee on Education of the Association, is the new president of the American Academy of Dermatology and Syphilology.

* * *

In order to provide more efficient working space for the expanding activities of the Ohio State Medical Association, the State Headquarters Office has been completely remodeled and re-decorated. The office occupies over 2,000 square feet, about one third of the top floor of the Hartman Theater Bldg. There are now 12 full-time employees on the staff.

* * *

"How's the Patient?", the weekly broadcast of the Columbus Academy of Medicine heard on Sundays at 12:15 p.m. over Station WBNS, recently completed its 400th airing. The program began in May, 1939.

* * *

A "Flowers for the Living" banquet at Houston, Texas, Dec. 4, honoring Dr. Holman Taylor, veteran secretary of the State Medical Association of Texas and member of the House of Delegates of the American Medical Association, ended tragically when Dr. Taylor died of a heart attack while greeting guests following the dinner.

* * *

A study of Princeton football statistics for the ten years 1933-42, reported in the *Journal-Lancet*, places the chances of injury at 69 in 100, and, once injured, the chances of a repeat performance at 7 in 10. The average time out with each injury was 5.2 days. One casualty in 25 was out for the season. Only 1 man in 100—8 men in a total squad of 780—was permanently knocked out of football.

* * *

At the Sixth Annual Saranac Symposium of the Edward L. Trudeau Foundation, recently, Dr. H. S. Van Ordstrand, Cleveland, gave an address on "Acute Beryllium Poisoning". Discussion on the paper was led by Dr. M. G. Carmody, consultant to the Clifton Products Company, Painesville.

* * *

The first construction project application to be completely approved under the Federal Hospital and Construction Act (Hill-Burton Bill), was given final approval Oct. 22 when Surgeon General Thomas Parran of the U.S.P.H.S. okayed plans for an 82-bed general hospital, public health center, and outpatient clinic at Langdale, Ala. The project will cost \$1,663,287, including site, equipment, and architect's fees.

Total enrollment in Blue Cross enrollment in the United States and Canada has now reached 29,000,000 persons, and is available in every state in the Union except Arkansas. During the year ended July 1, 1947, Blue Cross plans paid \$177,420,996 to hospitals for care of members. This represents 85 per cent of subscription income, according to Richard M. Jones, director of the Blue Cross Commission.

* * *

In a message addressed to the recent annual meeting of the American Public Health Association, President Truman urged the prompt adoption of a national health insurance system. During the meeting Surgeon General Parran recommended that medical schools begin now to increase the annual number of students graduated by 50 per cent.

* * *

Dr. Richard J. Plunkett is the new associate editor of *The Journal of the American Medical Association*. Formerly vice-president and director of the Division of Health and Sanitation of the Institute of American Affairs, Washington, D.C., Dr. Plunkett graduated from Tufts Medical College in 1933 and received his master's degree in public health from Harvard in 1939.

* * *

Clarence M. Taylor, Cleveland, named executive director of the Cleveland Clinic to fill the vacancy resulting from the death of Edward C. Daoust in an airplane accident last summer, was formerly executive vice-president of the Lincoln Electric Company of Cleveland.

* * *

The 1947 Alabama legislature enacted a statute providing for compulsory examinations for tuberculosis. The state health department is authorized to order tuberculosis examinations in any or all counties, affecting all persons between 13 and 50 years of age, except members of the Armed Forces.

* * *

Dr. Frank F. Tallman, Columbus, formerly state commissioner of mental hygiene, has been appointed a consultant in mental health to the United States Public Health Service, on expiration of his term on the National Advisory Mental Health Council. Council members cannot succeed themselves.

* * *

According to the *Statistical Bulletin* of the Metropolitan Life Insurance Company, pneumonia is rapidly becoming a minor cause of death. Influenza and pneumonia now rank eighth as a cause of death in the company's insurance experience, accounting for less than four per cent of the total mortality.

With the Veterans Administration —

THE Veterans Administration announced December 8 that prima facie evidence will not be accepted as sufficient proof for veterans to establish service-connection for medical and dental treatment after December 31.

On this date, veterans will have had a full year after the President announced the end of hostilities in which to secure treatment on the presumption of service-connection, based on prima facie evidence.

The V.A. takes the position that this should have been ample time for emergency or clearly defined service-connected cases to have received treatment.

The discontinuance of determination on prima facie evidence in no way denies veterans any rights they are granted by law, nor does it limit services given those whose conditions are rated as service-connected.

Applications for treatment received on or before December 31, or after that date with a December 31 postmark, will be determined on prima facie evidence and the presumptions prescribed in V. A. Circular 17, but applications received or mailed after that day will have to be formally adjudicated under the regulations, before treatment other than emergency can be given.

This ruling in no way affects the year's presumption of service-connection to which all veterans are entitled after discharge.

Legion Says Budget Cut Hurt V. A. Medical Care Program

The following article dealing with current difficulties in the program of out-patient medical care of the Veterans Administration was published in a recent issue of the *Ohio Legion News*, official publication of the Ohio Department, American Legion:

"Due to a lack of appropriated funds, the Veterans Administration is denying treatment for service-connected disabilities to qualified veterans. Although the Congressional Committee which approved the V.A. budget for 1946-47 stated that it had no intention of reducing direct service to veterans, the appropriation made for out-patient service has proven inadequate to do the job our service-connected veterans deserve. The funds allotted to each V.A. Office since last June 30th have been about half enough to do the whole job and so the funds allotted are used up in about half the length of time the fund is scheduled to last. As a result, the veteran who asks for out-patient treatment in the latter part of any allotment period will find his application back-logged until the first part of the succeeding allotment period. This back-log is piling up and veterans find it easier to see their own physician or dentist privately, than to wait months for V.A. attention.

"Our Cleveland V.A. Regional Office request for out-patient funds for the three-month period end-

How You Can Help Druggist In V. A. Program

The Ohio State Pharmaceutical Association has again requested the cooperation of physicians in the writing of V.A. prescriptions, as follows:

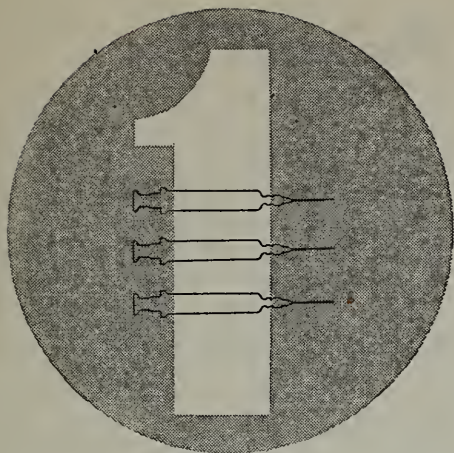
1. Be sure the V.A. beneficiary (patient) has been authorized for treatment during the month the prescription is written.
2. Write prescriptions for only the 14 items that have been approved and designated as "Medical Requisites" at this date.
3. Secure from the pharmacist a supply of V.A. prescription blanks which contain the printed statement "I am authorized to treat and prescribe for the above-named Veterans Administration patient". Use of these blanks will minimize the time of physicians in writing V.A. prescriptions.

Since the V.A. is rejecting for payment prescriptions filed by the pharmacist wherein the veteran has not been authorized for treatment or the item covered by the prescription is not an approved "Medical Requisite", the pharmacist, even though he accepts and fills the prescription in good faith, is not being reimbursed and thus suffers a financial loss on such prescriptions.

ing December 31, 1947, was reduced by the V.A. Budget Director to 40 per cent of the amount requested. The request from Cincinnati was whittled to 54 per cent of the original amount. This means that veterans will receive about half the out-patient service they need and to which they are entitled.

"The Department Executive Committee has passed a resolution asking that 'the V.A. proceed to furnish to veterans that out-patient care to which they are entitled, without restriction to a monthly allotment. Should it be found in the early part of 1948 that insufficient funds are left to carry on the program for the rest of the fiscal year, the V.A. should go to Congress, who authorized the out-patient treatment, requesting a deficiency appropriation of whatever amount is necessary to carry out the intent of Congress, and to provide care for disabled veterans.' This resolution has been forwarded to the National Organization of The American Legion for representation to the Rehabilitation Committee and the Executive Committee.

"If you are having difficulty in getting medical or dental treatment for your service-connected disabilities, you can blame this lack of funds. Only an aroused public opinion can do anything about it, so why not write your Congressman asking him to see that the V.A. is supplied the funds to do a good job of out-patient service."



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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

"Head Injuries", was the subject discussed by Dr. Thomas Weaver, Dayton, before the December 17 meeting of the Butler County Medical Society, held at the Anthony Wayne Hotel in Hamilton.—Bulletin.

CLINTON

The following physicians were elected to the offices of the Clinton County Medical Society at a meeting held in Wilmington, December 2: Dr. W. L. Regan, Wilmington, pres.; Dr. G. E. Garvin, Blanchester, vice-pres.; Dr. R. W. DeCrow, Wilmington, secy.-treas.; Dr. Edmond K. Yantes, Wilmington, delegate, and Dr. H. Richard Bath, Wilmington, alternate.

HAMILTON

Speaker at the December 16 meeting of the Academy of Medicine of Cincinnati was Dr. Robert H. Williams, assistant professor of medicine, Harvard Medical School. His subject was "Recent Developments in the Treatment of Thyrotoxicosis". The meeting was held in the Academy Auditorium, Union Central Annex Building, Cincinnati.—Bulletin.

WARREN

The following physicians are the new officers of the Warren County Medical Society: Dr. A. F. Lippert, Pleasant Plain, pres.; Dr. R. M. Brewer, Lebanon, vice-pres.; Dr. Arch D. Harvey, Lebanon, secy.; Dr. Mary Cook, Waynesville, treas.; Dr. O. L. Laymon, Franklin, delegate, and Dr. John Sharts, Franklin, alternate.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

Officers of the Clark County Medical Society for 1948 include the following Springfield doctors of medicine: Dr. F. A. Halloran, pres.; Dr. W. D. Beasley, pres.-elect; Dr. H. H. Ingling, secy.; Dr. G. M. Lane, treas.; Drs. D. W. Hogue and A. R. Kent, delegates; and Drs. R. M. Turner and F. Anzinger, Jr., alternates.

Speaker for the December 15 meeting of the society was Dr. A. J. Beams, associate professor of medicine, Western Reserve University School of Medicine. His subject was "Some of the Newer Aspects in the Diagnosis and Treatment of Liver Disease". The meeting was held at the Nurses' Home Auditorium of Springfield City Hospital.—Frank C. Bateman, executive secy.

DARKE

Newly elected officers of the Darke County Medical Society include: Dr. John R. Alley, Greenville, pres.; Dr. John Meyers, Versailles, vice-pres.; Dr. Maurice Kane, Greenville, secy.-treas.; Dr. J. E. Gillette, Versailles, delegate; and Dr. G. E. Sayle, Greenville, alternate.

MIAMI

Members of the Miami County Medical Society have elected the following officers for 1948: Dr. E. R. Irvin, Bradford, pres.; Dr. D. F. Deeter, Troy, vice-pres.; Dr. G. A. Woodhouse, Pleasant Hill, secy.-treas. and delegate; and Dr. B. M. Hogle, Troy, alternate. The officers were elected at the December 5 meeting of the society, held at the Stouder Memorial Hospital, Troy. A medical motion picture entitled, "Hypothyroidism, Etiology, Diagnosis, and Treatment" was shown.—G. A. Woodhouse, M.D., secy.

MONTGOMERY

Officers of the Montgomery County Medical Society for 1948 include the following Dayton doctors of medicine: Dr. N. C. Hochwalt, pres.; Dr. T. L. Light, vice-pres.; Dr. E. R. Arn, pres.-elect; Dr. Paul Troup, secy.; Dr. M. D. Place, treas.; Drs. M. D. Prugh, R. D. Dooley, R. S. Binkley, and A. W. Carley, delegates; and Drs. L. E. Baker, N. Shepard, R. E. Pumphrey, and R. C. Doan (Miamisburg), alternates.

"Newer Concepts of the Diagnostic Value of Changes in Retinal Arteries", was the subject of a paper presented by Dr. Albert L. Brown, assistant professor of ophthalmology, University of Cincinnati School of Medicine, before the December 5 meeting of the society, held at the Biltmore Hotel in Dayton.—Bulletin.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

ALLEN

Members of the Academy of Medicine of Lima and Allen County have chosen the following Lima physicians as officers for 1948: Dr. Lester C. Thomas, pres.; Dr. James M. McBride, pres.-elect; Dr. E. B. Young, secy.; Dr. Harold A. Lotzoff, treas.; Dr. Fred P. Berlin, delegate; and Dr. W. B. Light, alternate.

AUGLAIZE

The program of the December meeting of the Auglaize County Medical Society, held in St. Marys, included a report by Dr. F. J. Maurer of Lima on "Present Status of Heart Treatment", followed by a talk by Dr. W. B. Recker, Leipsic,

on the subject, "Organization of an American Academy of General Practice".—News Clipping.

CRAWFORD

The following are officers of the Crawford County Medical Society for 1948: Dr. R. L. Solt, Bucyrus, pres.; Dr. T. D. Sawyer, Crestline, vice-pres.; Dr. Carl Ide, Bucyrus, secy.-treas.; Dr. D. G. Arnold, Bucyrus, delegate; and Dr. D. D. Bibler, Bucyrus, alternate.

LOGAN

Newly elected officers of the Logan County Medical Society are: Dr. Omar C. Amstutz, Bellefontaine, pres.; Dr. Douglas Beach, Huntsville, vice-pres.; Dr. John B. Traul, Bellefontaine, secy.-treas.; Dr. Hobart L. Mikesell, West Liberty, delegate; and Dr. Warren Mills, Bellefontaine, alternate.

MERCER

The Mercer County Medical Society re-elected the following officers for 1948: Dr. M. L. Downing, Rockford, pres.; Dr. John Helfrich, Coldwater, pres.-elect; Dr. A. J. Rawers, Celina, secy.-treas.; Dr. E. J. Wilkie, Maria Stein, delegate; and Dr. G. H. McIlory, Celina, alternate.

VAN WERT

The following Van Wert physicians were elected to office for 1948 by the Van Wert County Medical Society: Dr. C. A. Morgan, pres. and delegate; Dr. O. E. Cress, vice-pres.; and Dr. R. E. Shell, secy.-treas. and alternate.

Speakers at the meeting of the Van Wert County Medical Society, December 2, at the Marsh Hotel, Van Wert, were George H. Saville, director of Public Relations of the Ohio State Medical Association, who discussed the activities of the Association, and Charles H. Coghlan, executive vice-president, Ohio Medical Indemnity, Inc., who explained "The Doctors' Plan". They were introduced by Dr. J. Craig Bowman, Upper Sandusky, Councilor for the Third District.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

FULTON

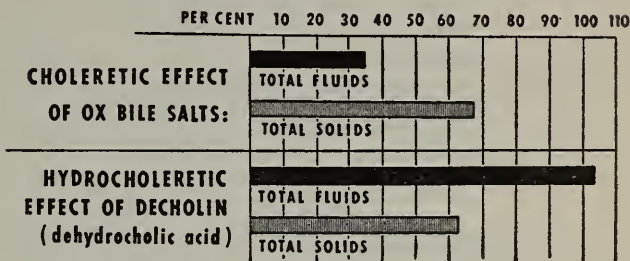
Dr. Ralph W. Reynolds, Fayette, was elected president at the annual meeting of the Fulton County Medical Society; Dr. William B. Ver Hey, Fayette, was chosen as vice-president, and Dr. Paul I. Geer, Metamora, secy.-treas. Dr. Carll Mundy, Toledo, Fourth District Councilor of the Ohio State Medical Association, addressed the meeting.—Paul I. Geer, M.D., secy.-treas.

LUCAS

The following section meetings were held in December by the Academy of Medicine of Toledo and Lucas County.

Dec. 12—Section of Pathology, Experimental Medicine and Bacteriology, "Carcinoma of the Cervix", Dr. Samuel G. Henderson, assistant

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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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professor of radiology, University of Pittsburgh Medical School.

Dec. 19—Medical Section, "Shock and Its Treatment", Dr. Irving Page, Cleveland. Meetings were held in the Academy Building.—Bulletin.

PUTNAM

Members of the Putnam County Medical Society elected the following as officers for 1948: Dr. A. H. Nihizer, Vaughnsville, pres.; Dr. H. H. Sink, Columbus Grove, vice-pres.; Dr. W. E. Martin, Columbus Grove, pres.-elect; Dr. Munroe Palestrant, Continental, secy.-treas.; Dr. W. B. Recker, Leipsic, delegate; and Dr. John R. Echelbarger, Ottawa, alternate.

WOOD

New officers of the Wood County Medical Society include the following physicians, all of Perrysburg: Dr. Paul F. Orr, pres. and delegate; Dr. Luther Pugh, pres.-elect; Dr. James R. McAuley, secy.-treas.; and Dr. F. V. Boyle, alternate.

A paper on "The Application of the Vaginal Smear Method to Genital Malignancy", was read by Dr. James E. Miller, Toledo, at the election meeting, which was held December 4 at Perrysburg. Dr. F. M. Teeple, Wood County Health Commissioner, was present and offered

information on recent health programs suitable for application in the area.—D. R. Barr, M.D.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

ASHTABULA

The 1948 officers of the Ashtabula County Medical Society are as follows: Dr. H. A. Tagett, Ashtabula, pres.; Dr. M. R. Martin, Geneva, pres.-elect; Dr. S. A. Burroughs, Ashtabula, secy.-treas.; Dr. R. B. Wynkoop, Ashtabula, delegate; and Dr. P. J. Collander, Ashtabula, alternate.

CUYAHOGA

The program of the regular meeting of the Academy of Medicine of Cleveland, December 19, was conducted by the Department of Preventive Medicine of the Western Reserve University School of Medicine. Subjects and speakers were: "Influenzal Pneumonia", Dr. Richard Hodges, assistant professor of preventive medicine; "Exudative Tonsillitis", Dr. C. H. Rammelkamp, associate professor of preventive medicine; and "Common Virus Diseases of the Respiratory Tract", Dr. John H. Dingle, Elisabeth Severance Prentiss professor of preventive medicine. The meeting was held in the Medical Library Auditorium in Cleveland.

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Dec. 3—Pediatric Section, "Repair Solutions in the Treatment of Dehydration", Dr. Allan M. Butler, director of pediatrics, Massachusetts General Hospital.

Dec. 5—Clinical and Pathological Section, "An Unusual Case of Meningioma", Dr. C. W. Elkins; "Sub-total Colectomy in a Case of Ulcerative Colitis", Dr. F. S. Gibson; "Regional Enterocolitis", Dr. J. H. Lazzari; "A Case of Polyarteritis Nodosa", Dr. M. August; and "Tumors of the Renal Pelvis", Dr. W. E. Forsythe.

Dec. 12—Experimental Medicine Section of the Academy, and Cleveland Section of the Society for Experimental Biology and Medicine, "Staphylococcal Penicillinase: A Precise Method of Assay, its Distribution, and its Relationship to Penicillin Resistance", Drs. Betty Gilson and R. F. Parker; "The Role of Ammonium and Potassium Ions in Alcoholic Fermentation", John Muntz, Ph.D.; "The Effect of Urethane on Transplanted Leukemia", Drs. David R. Weir and Robert W. Heinle; "The Placental Barrier in Erythroblastosis Fetalis and in Normal Pregnancy", Dr. Benjamin S. Kline.

Dec. 17—Obstetrical and Gynecological Section, "Diagnosis and Treatment of Carcinoma of the Cervix and the Fundus of the Uterus", Dr. J. Robert Andrews.—Bulletin.

LAKE

Newly elected officers of the Lake County Medical Society include the following Painesville doctors of medicine: Dr. G. O. Hedlund, pres.; Dr. F. J. Dineen, pres.-elect; Dr. P. E. Reading, secy.-treas.; Dr. M. G. Carmody, delegate; and Dr. G. R. Smith, alternate.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

The Columbiana County Medical Society has appointed a committee to formulate a long-range tuberculosis control program for that county. The action was taken November 13 at a meeting of the society, held at the Lape Hotel in Salem. Speaker for the meeting was Dr. Arnold B. Kurlander, chief of the Division of Tuberculosis Control of the Ohio Department of Health. Dr. Robert Dunlap of East Liverpool was named chairman of the committee.—News Clipping.

MAHONING

Dr. John H. Dingle, professor of preventive medicine, Western Reserve University School of Medicine, spoke on "Upper Respiratory Infections", at the November 18 meeting of the Mahoning County Medical Society, held at the Youngstown Club.—Bulletin.

PORTAGE

Officers chosen for 1948 by the Portage County Medical Society include: Dr. Walter B. Webb, Ra-



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venna, pres. and delegate; Dr. Richard C. Neely, Ravenna, vice-pres. and alternate; Dr. Emily J. Widdecombe, Kent., secy.-treas.

STARK

The following doctors of medicine have been elected to the offices of the Stark County Medical Society: Dr. G. L. King, Alliance, pres.; Dr. John R. Rohrbaugh, Massillon, pres.-elect; Dr. R. E. Tschantz, Canton, secy.-treas.; Dr. R. K. Ramsayer, Canton, delegate; and Dr. Harry Beck, Canton, alternate.

SUMMIT

Officers of the Summit County Medical Society for 1948 include the following Akron physicians: Dr. Robert M. Lemmon, pres.; Dr. David J. Roberts, pres.-elect; Dr. Lawrence B. Mehl, secy.; Dr. W. M. Johnston, treas.; Drs. V. C. Malloy, R. E. Pinkerton, Kurt Weidenthal (Hudson), and L. A. Witzeman, delegates; and Drs. W. T. Bucher, E. W. Burgner, J. D. Hayden, and R. E. Wetzal (Cuyahoga Falls), alternates.

Dr. Gerald B. Hurd, head of the department of gynecology, St. Luke's Hospital, Cleveland, presented a paper on "Practical Aspects of Office Gynecology", before the December 2 meeting of the society, held at the Nurses' Home, Akron City Hospital.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

Officers elected by the Belmont County Medical Society for 1948 include: Dr. Leo D. Covert, Bellaire, pres. and delegate; Dr. D. Myers Creamer, Bellaire, pres.-elect and alternate; Dr. Bertha M. Joseph, Martins Ferry, secy.-treas.

CARROLL

Officers of the Carroll County Medical Society for 1948 are: Dr. Carl A. Lincke, Carrollton, pres.; Dr. P. S. Whiteleather, Minerva, pres.-elect; Dr. Charles H. Dowell, Carrollton, secy.-treas.; Dr. Joseph Stires, Malvern, delegate; and Dr. S. L. Weir, Minerva, alternate.

JEFFERSON

At the regular meeting of the Jefferson County Medical Society, held December 2 in Steubenville, Drs. Frank Gregg and J. J. McAleese, of Pittsburgh, spoke on "Congenital Heart Disease and Its Treatment".—Sanford Press, M.D.

TUSCARAWAS

The following New Philadelphia doctors of medicine will be the officers of the Tuscarawas County Medical Society during 1948: Dr. Burrell Russell, pres.; Dr. C. M. Dougherty, pres.-elect and delegate; Dr. H. F. Wherley, secy.-treas.; and Dr. J. C. Blinn, alternate.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

ATHENS

The following doctors of medicine, all of Athens, were elected to office for 1948 by the members of the Athens County Medical Society: Dr. P. J. Woodworth, pres.; Dr. Beatrice Postle, pres.-elect and alternate; Dr. C. R. Hoskins, secy.-treas.; and Dr. L. A. Hamilton, delegate.

GUERNSEY

Newly elected officers of the Guernsey County Medical Society, all of Cambridge, are: Dr. E. E.

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Conaway, pres.; Dr. W. L. Denny, vice-pres.; Dr. Robert A. Ringer, secy.-treas.; Dr. J. A. L. Toland, delegate; and Dr. J. D. Knapp, alternate.

MUSKINGUM

Dr. Philip J. Reel, Columbus, spoke on the subject, "The Importance of Early Diagnosis of Cancer of the Cervix" at the December 3 meeting of the Muskingum County Academy of Medicine, held at the University Club in Zanesville.—Beatrice T. Hagen, M.D., secy.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

HOCKING

The Hocking County Medical Society elected Dr. J. Ward Doering, Logan, as president for 1948; Dr. C. T. Grattidge, Laurelville, vice-president; and Dr. Owen F. Yaw, Logan, secretary-treasurer. Dr. Robert Keating of the Ohio State University College of Medicine discussed urological problems at the meeting, which was held November 18 at the Hocking Valley Hospital.—Owen F. Yaw, M.D., secy.

PIKE

New officers of the Pike County Medical Society include: Dr. P. H. Jones, Stockdale, pres.; Dr. L. E. Wills, Waverly, vice-pres.; Dr. Charles A. Clifton, Piketon, secy.-treas.; Dr. Charles L. Critchfield, Waverly, delegate; and Dr. Mack E. Moore, Piketon, alternate.

SCIOTO

The following Portsmouth doctors of medicine have been elected to the offices of the Hempstead Academy of Medicine: Dr. Elizabeth Long, pres.; Dr. Ruth B. Bennett, pres.-elect; Dr. J. P. McAfee, secy.-treas.; Dr. W. A. Quinn, delegate; and Dr. Dow Allard, alternate. The annual banquet of the academy was held December 8 at the Elks Country Club, Portsmouth.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

New officers of the Columbus Academy of Medicine include the following Columbus physicians: Dr. Harve M. Clodfelter, pres.; Dr. Gilman D. Kirk, pres.-elect; Dr. Reuben B. Hoover, secy.-treas.; Drs. Drew L. Davies, George J. Heer, Grant O. Graves, Warren G. Harding, Charles W. Pavey, and Franklin C. Hugenberger, delegates; and Drs. John J. Gallen, W. L. Pritchard (Hilliards), Howard R. Mitchell, Thomas E. Rardin, George F. Collins, and A. Ruppertsberg, Jr., alternates.

Dr. Cyrus S. Sturgis, chairman of the department of internal medicine, University of Michigan Medical School, discussed "Thyrotoxicosis and Exophthalmic Syndromes" before the De-

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cember 1 meeting of the Academy, held at the Columbus Gallery of Fine Arts. Dr. Andre Crotti of Columbus was discussant. The academy's annual dinner party and dance was held December 10 at the Athletic Club, Columbus.

MADISON

Officers of the Madison County Medical Society for 1948 are: Dr. J. William Hurt, West Jefferson, pres.; Dr. Sol Maggied, West Jefferson, secy.-treas.; Dr. W. A. Holman, London, delegate; and Dr. William T. Bacon, London, alternate.

MORROW

Dr. E. C. Sherman of Cardington was honored by the Morrow County Medical Society, November 11, with a gift from the society in recognition of his practice of medicine in that county for more than 51 years. Guests at the meeting were: Dr. H. M. Clodfelter, Columbus, Tenth District Councilor of the Ohio State Medical Association, and Dr. H. M. Platter, Columbus, Secretary of the Ohio State Medical Board.

ROSS

The following Chillicothe physicians were elected to the offices of the Ross County Academy of Medicine for 1948: Dr. R. C. Bane, pres.; Dr. E. H. Artman, pres.-elect; Dr. W. E. Kramer, secy.-treas.; Dr. R. W. Holmes, delegate; and Dr. O. P. Tatman, alternate.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M. D., SANDUSKY)

LORAIN

Officers of the Lorain County Medical Society for 1948 include; Dr. George A. Hoke, Elyria, pres.; Dr. Leonard A. Stack, Lorain, vice-pres.; Dr. L. H. Trufant, Oberlin, secy.-treas.; Drs. John T. Fawcett and Swen D. Nielson of Elyria, delegates; and Drs. Charles R. Meek and Valloyd Adair, of Lorain, alternates.

Dr. Harry V. Paryzek, director of medicine, St. Alexis Hospital, Cleveland, presented a paper on "Medical Emergencies", at the December 9 meeting of the society, held at Elyria.—L. H. Trufant, M.D., secy.

MEDINA

Officers of the Medina County Medical Society for 1948 are: Dr. Morris Wilderom, Medina, pres.; Dr. L. S. Zwick, Wadsworth, pres.-elect; Dr. J. G. Martin, Wadsworth, secy.-treas.; Dr. W. B. Houston, Valley City, delegate; and Dr. T. V. Kolb, Litchfield, alternate.

WAYNE

Dr. Rolla E. Hoffman, for 30 years a surgeon at the American hospital, Meshed, Iran, addressed the November 12 meeting of the Wayne County Medical Society, following the society's annual dinner. Dr. Hoffman discussed leprosy.

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Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting, February 2, March 1, March 29.

Surgical Anatomy & Clinical Surgery, two weeks, starting February 16, March 15.

Surgery of Colon & Rectum, one week, starting March 8, April 26.

Surgical Pathology every two weeks.

FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting April 26.

GYNECOLOGY—Intensive Course, two weeks, starting February 23, March 29.

Personal Course in Vaginal Surgery starting February 16, March 22.

OBSTETRICS—Intensive Course, two weeks, starting March 15, April 12.

MEDICINE—Intensive Course in Gastroscopy, two weeks, starting March 29, April 19.

Electrocardiography & Heart Disease, four weeks, starting February 16, May 3.

CYSTOSCOPY—Ten-day Course starting January 5, January 19, February 2.

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Woman's Auxiliary News

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

CLARK

Speaking on "What Every Doctor's Wife Should Know About Public Relations" before a meeting of the Woman's Auxiliary to the Clark County Medical Society, held November 17 in the nurses' residence of the Springfield City Hospital, George H. Saville of Columbus, director of Public Relations for the Ohio State Medical Association, cited the individual doctor as the cornerstone in building good relations and pointed out the ways the doctor's wife could assist him.

Mr. Saville described the public relations department as one existing for the purpose of rendering service to the public in matters relating to the profession rather than one of publicity or sales promotion. He spoke of the work of the department of the Ohio State Medical Association in circulating literature on health topics to both doctors and laymen, radio health talks, assistance in placing doctors where needed, of the prepaid medical care plan sponsored by the Association, and of their efforts to support legislation which the medical profession believed would serve the best interests of the public and to oppose that which would not.

A business meeting preceded the program and yearbooks were distributed. Mrs. E. R. Brubaker asked for volunteers to speak in the schools in the interest of nurses' recruitment. Mrs. A. A. Gavey is chairman of a committee which will make slippers for use at the hospital. Mrs. H. B. Elliott asked members to contribute to a fund to buy Christmas gifts for the residents of the Clark County Home.

Following the meeting a joint social hour was held with the County Medical Society, and a buffet lunch was served.

COLUMBIANA

A regular meeting and luncheon of the Woman's Auxiliary to the Columbiana County Medical Society was held Thursday, November 6, at the Hotel Wick in Lisbon. Dr. B. B. McGuire was the guest speaker. His subject was "Public Health Work". A business meeting was held and new officers were elected. Mrs. Chester Dewalt, Columbiana, was elected president.

ERIE

The first meeting of the Woman's Auxiliary to the Erie County Medical Society since its organization on October 7, was held on Tuesday afternoon, November 11, at Plum Brook Country Club.

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The speaker was Mrs. J. L. Stevens of Mansfield. The auxiliary has 30 charter members, and Mrs. Ross Knoble is president.

FAIRFIELD

While members from the Eighth District of the Ohio Medical Association were attending their meeting in Lancaster on Thursday, November 13, wives of members were entertained at the local country club. The hosts and hostesses were members of the Fairfield County Medical Society and the members of the Woman's Auxiliary. Bridge was played throughout the afternoon at the country club. Table favors were awarded and later dinner was served to 47 members and guests.

FRANKLIN

The regular monthly meeting of the Woman's Auxiliary to the Columbus Academy of Medicine was held at the Nurses' Home, St. Francis Hospital, Monday afternoon, November 17.

Special guests at this meeting were Mrs. Harold Mouser, Marion, state president; Mrs. E. B. Gillette, Toledo, state president-elect; and Mrs. Paul A. Davis Akron, past-president, together with guests from Fayette, Knox, Madison, Pickaway, Ross, Union, Delaware, and Morrow counties.

Dr. Charles A. Doan, dean of the College of Medicine at Ohio State University, was the speaker. Dr. Doan's subject was, "The Plans and Program of the College of Medicine at Ohio State University". A tea and social hour followed the meeting.

GUERNSEY

The Guernsey County Medical Auxiliary met November 6 at the home of Mrs. James A. Toland. Luncheon was served by Mrs. Toland with the assistance of Mrs. Reo Swan and Mrs. Benjamin Gillespie. After a short business meeting and a report on the auxiliary meeting held in Columbus two weeks previously, the rest of the afternoon was spent in sewing pillow cases for Cambridge State Hospital.

LICKING

On Tuesday evening, December 2, members of the Auxiliary to the Licking County Medical Association assembled at the home of Mrs. R. W. Jones, Newark, for dinner. Mrs. Carl L. Petersilge was a guest of the group. The time was spent in making Christmas stockings for the Red Cross and the auxiliary will donate gifts to be sent to the veterans at the Chillicothe Hospital.

LUCAS

On November 17, 65 members of the Woman's Auxiliary to the Toledo Academy of Medicine were guests of a local automobile manufacturer. After luncheon was served in the plant cafeteria, the women were taken in station wagons over to the factory. The first stop was the

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hospital and from there a complete tour of the assembly line was made. Mrs. Charles Phillips, public relations chairman, arranged the trip.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society made more than \$350 from their recent bazaar. With this money they presented to the Children's Ward of the Youngstown City Hospital a radio-victrola combination cabinet. A cash donation equaling the cost of the above machine was presented to St. Elizabeth's Hospital for the purchase of two new beds for the children's ward.

On December 23, the Auxiliary gave a Christmas party for all patients at the Youngstown Receiving Hospital.

MUSKINGUM

The Woman's Auxiliary to the Muskingum County Medical Association held a "blind auction" after its December luncheon meeting at the Hotel Rogge. Bridge was also played in the afternoon.

OTTAWA

The Medical Auxiliary to the Ottawa County Medical Society met with Mrs. L. L. Belt, Lakeside, for its October meeting. The business meeting was spent in finishing the Constitution. Mrs. J. C. Whitaker, of Lakeside, was appointed program chairman. Mrs. A. D. Miessner, the public relations chairman.

PICKAWAY

The Woman's Auxiliary to the Pickaway County Medical Society sponsored Dr. Esther Fabing Marting, Cincinnati, in an address on cancer, at the October meeting in St. Philip's Parish House.

Mrs. R. S. Hosler, Ashville, president, presided. The group plans to sponsor a constructive project such as Dr. Marting's address, once or twice a year for the citizens of Pickaway County and Circleville. Preceding the address, members of the Medical Society and the Woman's Auxiliary honored their guest with a dinner in Pickaway Arms. Places were set for 26 members of the organizations.

ROSS

Fifteen members of the Woman's Auxiliary to the Ross County Academy of Medicine met recently for dinner in Chillicothe. Mrs. John Franklin conducted the after-dinner business session and led a discussion on fund-raising projects. Mrs. George Cooper, Clarksburg, displayed the auxiliary scrapbook which she is editing. Dr. Russell C. Bane spoke on "The Uses and Benefits of Infant Resuscitator". An exchange of Christmas gifts followed.

STARK

Members of the Woman's Auxiliary to the Stark County Medical Association heard a stimu-


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lating address on "American Dialects" by Dr. Eric Eckler, head of the English Department of Mount Union College, when they met on October 7 at the Alliance Woman's Club.

TRUMBULL

The monthly meeting of the Woman's Auxiliary of the Trumbull County Medical Society was a luncheon meeting on October 17.

At the business meeting plans were made for a bake sale which was held November 8. It was decided to give a Christmas gift to each woman at the County Home.

The guest speaker for the afternoon was Dr. G. Scullard of Warren City Hospital, who gave a talk on the Rh factor. This was followed by a discussion on ways to obtain Rh negative donors for the Warren Hospitals.

TUSCARAWAS

Fifteen members of the Tuscarawas County Medical Auxiliary enjoyed their November meeting at the home of Mrs. V. C. Nipple in Midvale. Final plans were made for the pre-Christmas bazaar and bake sale held December 6. Many lovely articles were made by the members. Mrs. C. J. Miller, New Philadelphia, was elected president for the ensuing year.

WASHINGTON

Sixteen members of the Auxiliary to the Washington County Medical Association and one guest enjoyed the dinner meeting at the Betsey Mills Club in Marietta.

Mrs. Ford Eddy presided at the business meeting and introduced Mrs. Paul McCuskey of Parkersburg, the guest speaker.

A benefit bridge and style show, given for the benefit of the hospital fund, was held November 19 at the Betsey Mills Club.

WOOD

The Woman's Auxiliary to the Wood County Medical Society was organized November 4 at the home of Mrs. H. W. Mannhardt, Bowling Green. The tentative charter list includes names of 11 members. Mrs. Mannhardt was chosen president.

Issue Joint Supply Catalogue

Just off the press is the Joint Army-Navy Catalogue of medical material which will supplant the separate Army and Navy medical supply catalogues heretofore in use. There are 5,026 items adaptable for both Army and Navy use, plus 1,581 Army-only, and 373 Navy-only entries. The U.S. Public Health Service and the Veterans' Administration have indicated that they will adopt a similar style in future catalogues.

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Society Section To Meet in Columbus

The Middle Section Meeting of the American Laryngological, Rhinological and Otological Society, Inc., will convene January 19 at the Deshler-Wallick Hotel in Columbus for a one-day session. The meeting, which includes a scientific program, will begin at 9:30 a.m., and is open to the medical profession. States represented in the Middle Section are Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, Oklahoma, Kansas, New Mexico, Colorado, Wyoming, Nebraska, North and South Dakota, and Texas. Dr. Hugh G. Beatty, Columbus, is Section Chairman.

A.M.A. Receives Research Award

At ceremonies conducted in New York City, December 16, the American Medical Association received the 1947 award of the American Pharmaceutical Manufacturers' Association in recognition of its fundamental contributions to public health in the field of medical research.

As part of the \$14,000,000 cancer research and control program authorized at the last session of Congress, the U.S. Public Health Service has awarded more than \$375,000 in grants for special research in improving technics for professional cancer instruction, a nation-wide survey of cancer clinics, and evaluation of cancer control measures. Ohio State University College of Medicine received \$24,800 for a project on the coordination of cancer teaching.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

WANTED: Public Health Commissioner in Tuscarawas County, New Philadelphia, Ohio. Must have degree in public health, to serve in county with a population of 40,000; the salary, \$6,600, plus traveling expenses. Write Office of Tuscarawas County Board of Health, New Philadelphia, Ohio.

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The Physician's Bookshelf

Headache, by L. G. Moench, M.D., (\$3.50. *The Year Book Publishers, Chicago*) presents a timely monograph of 200 pages. Headaches have always interested your reviewer. Several times he has written of them in the pages of *The Journal*. We recommend this book and join von Storch in his paraphrase of Oliver Wendell Holmes when he said: "If I wished to show a student the difficulties of medical practice, I should give him a headache to treat." All of you who have not done so, should become familiar with the brilliant researches of Wolff, the observations of Riley, von Storch, Lennox, Horton, and the leading American allergists, Vaughn, Rewe, et al.

The Doctor and the Difficult Child, by William Moodie, M.D., (\$2.00. Second Edition. *The Commonwealth Fund, New York City*) is an informal discussion of fundamental disturbances of behavior or personality in children. It tells how they can be recognized, investigated, and treated. This second edition has been revised by this distinguished British psychiatrist in the light of what was done to the children of England. These were not peculiar or unusual difficulties but only exaggerations at times of what you and I see in our children patients.

Colloid Science. A Symposium, by eleven contributors, (\$6.00. *Chemical Publishing Company, Inc., Brooklyn, New York*) is the American edition of a series of lectures given at Cambridge University. The growing interest in colloid systems, polymers, and macro-molecules, justifies the publication of these inspiring lectures. They come from a University department devoted to bridging the gap between the biological and the non-biological sciences. From this area is bound to come the next great advances in allergy and other branches of clinical medicine.

History of Medicine, by Cecilia C. Mettler, Ph.D., edited by Fred A. Mettler, M.D., Ph.D., (\$8.50. *Blakiston Company, Philadelphia*) is a correlative text arranged according to subjects. This, of course, has its drawbacks but at the same time increases its value as a work of reference for those with special interests. The work represents years of hard work and will stand as a monument to its author. Certainly every hospital library should have a copy and I being interested in the history of my profession, would recommend it to every physician.

Internal Medicine in General Practice, by Robert P. McCombs, M.D., (\$8.00. Second Edition. *W. B. Saunders Company, Philadelphia*) has covered the broad field in a relatively small volume and has done it well. For instance, allergic dis-

ease is covered in an exceedingly fine fashion in 23 pages. If you want to take a postgraduate course at home, here is the text!

The Metropolitan Life, A Study in Business Growth, by Marquis James, (\$5.00. *The Viking Press, New York City*) is the story of the rise as a social force of the largest private corporation in America. James has produced an excellent story with the dramatic material at hand and documents it all. Every citizen ought to read this book in order to understand the growth of the American social order and to get a prospective on Big Business. The more to realize that it is not the "Commies" in America who threaten our way of life, it is the "watery moralities of the collectivists in Washington and their supporters on college and university faculties.

Handbook of Psychiatry, by Winfred Overholser, M.D., and Winifred V. Richmond, Ph.D., (\$4.00. *J. B. Lippincott Company, Philadelphia*) is a simple, straightforward presentation of the elements of the various types of mental disease, their causes, symptoms, and prospects. The college student, the nurse, the average relative of mentally ill, and those of us physicians who have shied at the more technical volumes on this subject, may gather an understanding of the field of today.

Infant Nutrition, by P. C. Jeans, M.D., and W. McK. Marriott, (\$6.50. Fourth Edition. *C. V. Mosby Company, St. Louis, Missouri*) is a revision of a standard textbook on *Infant Feeding*. The revision has been complete including all advancements in nutrition applicable to infants.

Neuropathology, by I. Mark Scheinker, M.D., (\$6.75. *Charles C. Thomas, Springfield, Illinois*) is by one of our members and has a foreword by Tracy J. Putnam, M.D. It deals more directly with the clinical aspects of this neglected subject. What is more important to most of us, it is written in our kind of English.

Manual of Physical Diagnosis, by E. B. Freilich and George Cole, (\$5.00. Third Edition. *The Year Book Publishers, Chicago*) incorporates definite improvement over the previous two editions, in that new signs and diagnostic syndromes have been added. In addition, there are new chapters on the examination of the breast and the nervous system.

The Oculatory Muscles, by Richard G. Scobee, M.D., (\$8.00. *C. V. Mosby Company, St. Louis, Missouri*) is a successful attempt to produce a relatively simple, logical approach to the diagnosis of dysfunction of the oculatory muscles.

Tomorrow's Food

THE problem of getting enough food is not so simple for the family but it is much more difficult for a nation. To get enough of the right kind is even more difficult. It now seems clear that we are not going to produce food concentrates in pill form to feed the ever increasing number of world inhabitants in the presence of a steady decline in soil production. We may have to resort to growing non-fermenting yeasts on cellulose (sawdust and other plant wastes) in order to provide all with protein and other essentials. More recently a well-known mid-Western nutritional chemist has announced the perfection of a plan by which we can grow 40 per cent protein grasses and from these extract the protein, the water-soluble vitamins and minerals, and finally the oil-soluble vitamins. This plan offers something like three thousand dollars income per acre and a 16-cent daily ration in terms of our present phoney money.

To forget the more distant future and look only at today's and tomorrow's needs; how to keep our health through maintaining a good nutrition; how working with other peoples throughout the world we can both have better and more nutritious food, is told in an excellent book by Rorty and Norman. (*Tomorrow's Food. The Coming Revolution in Nutrition*, by James Rorty and N. Philip Norman, M.D., with a foreword by Stuart Chase. \$3.50. Prentice-Hall Inc., New York, N. Y.)

Certainly we physicians, as civic leaders with a responsibility, should begin to take an interest in the tangled mess of our food economy and culture. With the coming of the machine age, food became not only a necessity for life but a market commodity that could be shipped from the farm to distant cities and sold for cash. To feed the ever increasing horde of city-dwellers, the shrinking number of people on the farms developed an agriculture which put the emphasis on the volume and not on the value and price became more important than quality. There also developed machines with which to refine and process these foods so that they would keep. Thus white flour and white sugar came to dominate the market places of the world.

In the meantime, the "creative psychiatry" of the metropolitan "hucksters" was used most effectively to create a demand for what "the best people" thought was attractive. In this way through over-refinement then our foods became devitalized and depleted of their natural nutrients. Last year, we of the United States spent \$1,000,000,000 for candy—just one form of sugar use. Add to this our pasteries and our stimulating sweet water beverages and you can see how warped our sense of values has become. Truly our real educators are the hucksters for

we spend \$7,000,000,000 for liquor and tobacco (one fourth the consumers' food dollar) and one tenth as much on religious and welfare activities (\$700,000,000). Rorty and Norman realize all of this. They do not treat the problem as a simple one at all. On the contrary, they have shown us its ramifications into the economic, social, and political fabrics of our society. For instance, take their magnificent exposé of the sugar dilemma in which we find ourselves. We know what sugar does to our teeth and to our health and we know what the sugar industry has done to the people of the cane growing areas—especially our national responsibility to Puerto Rico and Cuba. In effect, sugar has starved both the producer and the consumer. It is therefore as much a problem for the economist and the statesman as it is for those who are interested in the health of our people.

They emphasize the depth to which our ethics dropped when on December 9, 1942, Mrs. Eleanor Roosevelt and the Quartermaster General went on the air over a coast-to-coast hook-up by "The Council on Candy as a Food in the War Effort"—a concoction of The National Confectioner's Association.

The authors summarized the quest of health by a review of the Medical Testament of the Cheshire physicians in England. This British report to the nation on "the illnesses that result from a lifetime of wrong nutrition" has attracted attention. It was reproduced in Sir Albert Howard's *Soil and Health*. An American edition of the thoughts of the physician who was the prime instigator of this testament will soon appear and thus supplement the work of Rorty and Norman. (*Sun, Soil, and Medicine*, by James Picton, Devin-Adair, New York.)

They repeat Dr. Wrench's story of the healthy Hunzas of India whose regular diet when fed to rats turned them into veritable rodent Methuselahs. They recall the draft rejection figures to show that an appalling number of them were due to bad food. Thus confounding themselves and others who say that if every citizen could run into a doctor's office for free whenever he took a notion, that we could do away with disease and physical defects.

Rorty himself has done a good job of evaluating "the heretics and evangelists". He calls our attention to the lives and contributions of the three great men as synthesizeers who proclaim the unity of the natural order and for whom the enemy is the inertia of our thinking, the fragmentation of the scientific disciplines, and the unequal development of natural and social sciences which by general admission constitute the central problem of our era. Ed Faulkner, of Elyria, and *Plowman's Folly*, has done a great

service by making us all think and the soil specialist re-evaluate his methods. Doctor Rudolph Steiner, who gave us the plant extracts that the biodynamic farmers use to hasten their composting, also taught that soil is a dynamic unity that must be kept in balance. This concept seems to be taking hold. The ecological observations of Rudolph Steiner and his pupil, Dr. Ehrenfried Pfeiffer, are making distinct impression upon American agriculture and all for its good.

* Finally, the last of these three great figures, Sir Albert Howard. Sir Albert had already arrived as a leader in the official priesthood of agriculture research and teaching in the British Empire when he broke with tradition. Rorty paints a clear picture of this great man—recently deceased—as one who did so much to prove that we can keep our health by eating food grown on fertile soil and unspoiled in its preparation. He insisted upon the importance of organic matter in the soil and upon the necessity of returning to the soil that which we borrowed, for this he recommended composting. For this he developed his own technique.

The Cheshire physicians followed his instructions for they realized, as do you and I, that once sickness enters the body, the body can never be restored. We may stop infections. Nature may repair the damage but neither she nor we can restore that body to its original perfection. Moreover they all teach and correctly, that sick people, sick animals, and sick soils cannot be corrected separately. *Creative Medicine*, as Sir Albert called it, is in fact a revolutionary way of life.

Today some men are beginning to realize what our machines have done to our food, to the soil farms on which it grew, and to our health, our economy and national policies.

James Rorty, a well-known free-lance writer, has learned these things through study and unfortunate personal experiences. Dr. Norman is a physician in New York City who for many years has been reconstructing human beings through the proper use of good foods. We can place these authors among those who grasp the significance of eating refined foods from depleted soils temporarily energized by a few of the many chemicals which are missing but essential to the completely healthy growth of plants. They also appreciate how complicated all of this problem is. They know for certain that they are tugging at one of the broken strands of the tangled mess of our culture but they have shown us where that strand leads into our health, our economy, our social and political institutions, and even into our international relations. For people with hidden hungers will not listen to talks of peace.

—JONATHAN FORMAN, M.D.

Physician's Bookshelf

Medicine For Moderns, by Frank G. Slaughter, M.D., (\$3.50. *Julian Messner, Inc., New York City*) is a presentation of psychosomatic medicine—a popular treatise by the physician-writer of Jacksonville.

Marriage Is On Trial, by Judge John A. Sbarbaro, (\$2.00. *Macmillan Company, New York City*) is divided into four parts. An ounce of caution, a pound of cure, marriage and the future, and facing the realities if you get a divorce. An excellent essay on marriage dedicated to those who have tried but failed.

Endogeneous Endocrinotherapy Including the Casual Care of Cancer Compendium, by Dr. Jules Samuels (*Holdbert and Company, Amsterdam, Holland*). The author believes that his work in this field is now an established science. He is busily engaged in setting forth the details in a five-volume opus. In the meantime, his friends have wished that he give the world a compendium so that we might know that "it is possible to find the etiology of a large number of diseases which are caused by a hypophyseal dysfunction and to learn of an effective therapy".

Physical Medicine in General Practice, by William Bierman, M.D., (\$8.00. Second Edition. *Paul B. Hoeber, Inc., New York City*) incorporates all the new advances including early ambulation for the various medical and surgical conditions. The major development in this field is the recognition of the responsibility society owes its handicapped. Dr. Sidney Licht has added an excellent chapter on rehabilitation covering this important aspect of postwar medicine.

Practical Clinical Psychiatry, by Edward A. Strecker, M.D., F. G. Ebaugh, M.D., and Jack R. Ewalt, M.D., (\$5.00. Sixth Edition. *The Blakiston Company, Philadelphia*) has reached more editions than any other psychiatric text. This record justifies its existence and should recommend its reading to all physicians. Something like two out of three patients who consult a physician are in need of psychiatric assistance and so here is a text with which we should be familiar.

Physiology and Pathology of the Newborn. Bibliography of Material for the period 1930-1940, compiled by A. N. Anthony. A monograph of the Society for Research in Child Development, Volume X, Series 41, No. 2 (*National Research Council, Washington, D.C.*)

Gifford's Textbook of Ophthalmology, by Francis H. Adler, M.D., (\$6.00. Fourth Edition. *W. B. Saunders Company, Philadelphia*) brings this valuable student text up to date without disturbing Gifford's original design and purpose.

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JONATHAN FORMAN, M.D., *Editor*

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Chemotherapy in Infants and Children I-Sulfonamides

J. G. KRAMER, M. D.

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CHART I

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Pneumococcus
Staphylococcus
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Clostridium Welchii
Klebsiella Pneumoniae
Urinary tract infections with
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E. Typhosus
A. Aerogenes
B. Pyocaneus
B. Proteus

Chart I shows the list of bacteria susceptible to sulfa therapy. The first five organisms produce the most frequent and most severe infections the pediatrician is called upon to treat. The lower group under urinary infections, combined with the organisms in the upper group comprise the commonest organisms that attack the urinary tract. To feel that we can combat infections produced by these organisms is truly an epical milestone in the path of Modern Medicine. Lest

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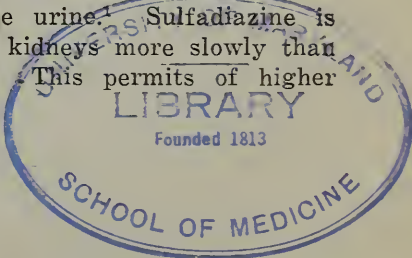
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we become too optimistic at this point it must be added that not all the organisms respond to the same degree. For example, Staphylococci as a rule are more resistant to therapy than the Pneumococci. Again various strains of the same organism have a varied defense, either inherited or acquired.

Damagk, in 1935, introduced Prontosil as the first sulfonamide. Since then numerous chemical modifications of the original product have been produced. These resulting sulfonamides have, after clinical trial, shown different absorption and excretion times as well as varied toxicity and clinical effectiveness. Without going into the merits and demerits of the various products, sulfadiazine stands out as the most acceptable, all-purpose drug. It may eventually be supplanted by a newer and more efficient product.

Sulfadiazine is absorbed slowly from the intestinal tract. Nearly one third of the drug is conjugated to a combined, non-therapeutic form by the liver. This conjugated form is fairly soluble and is readily excreted along with the free form in the urine. Sulfadiazine is excreted through the kidneys more slowly than other sulfa products. This permits of higher



and more effective blood levels with moderate dosage, thus necessitating close observation of the patient for kidney damage or block. The incidence of common toxic symptoms with sulfadiazine is only one third that encountered with sulfathiazole, sulfapyradine, or sulfanilamide. Sulfadiazine once absorbed, is distributed throughout the tissues and fluids of the body in concentrations closely approximating that of the blood. The drug penetrates the spinal fluid to at least 50 per cent of the blood level. Sulfamerazine is the only product that might challenge sulfadiazine for the place as an all-purpose drug.² Smaller doses of sulfamerazine will produce higher blood levels that are sustained because of the slow excretion by the kidneys. Consequently doses need to be given less often. Toxic effects are certainly as frequent and as severe as with sulfadiazine. Clinical results seem to be equal. Some reports however show a wide variation in absorption and excretion of sulfamerazine. Until further work is available sulfadiazine is the drug of choice.

The sulfonamides are not bacteriolytic. Bacteria can survive and live in a non-nutrient solution containing sulfonamides. However, in a nutrient media the bacteria do not survive. This is evidence that in some way they delay or inhibit the multiplication of the organisms. This bacteriostatic action of the sulfonamides is prevented by tissue or yeast extracts as well as pus. Further study showed a particular substance known as para-aminobenzoic acid in the extracts to have a specific antagonism to the sulfonamides. When various mixtures of para-aminobenzoic acid and sulfonamides were used in culture media the effect of the sulfonamides was neutralized. The rate of growth depended upon the amount and excess of para-aminobenzoic acid. Para-aminobenzoic acid is an essential metabolite for the growth of bacteria. The sulfonamides have a very close structural similarity to para-aminobenzoic acid so these two substances probably compete for the services of an enzyme essential to the life of the bacteria and this interference or substitution accounts for the bacteriostatic action.

A great many organisms normally sensitive to sulfonamides develop increased resistance after a short or long contact with the drug. But for the advent of penicillin, the increasing sulfonamide resistance of the Gonococci would have become a problem of grave epidemiological importance. With some bacteria the development of resistance is accompanied by increased production of substances that inhibit the antibacterial action of sulfonamides. This could be due to an increased production of para-aminobenzoic acid or the metabolism of the bacteria may be so altered that para-aminobenzoic acid is dispensed with. The possibility of the organisms developing a drug fastness makes it imperative

that we treat the infections intensively by giving large doses of the drug, never permitting the organisms to become acclimated to low sulfa blood levels and thus build increasing resistance to higher blood levels of the drug.

Sulfadiazine is best administered by mouth in the dosage of one grain per pound body weight per twenty-four hours, divided into four or six equal doses administered every four or six hours around the clock. The drug must be given day and night if a constant blood level is to be maintained. For the initial dose it is best to give twice the maintenance four- or six-hourly dose. For critically ill patients with blood stream infections, meningitis, osteomyelitis, or the like, two or even three grains of sulfadiazine may be given per each pound of body weight for twenty-four hours.

When patients are vomiting, unconscious, or antagonistic, and cannot or will not take sulfa by mouth, a parenteral route has to be found. In adults and older children intravenous medication can easily be administered. There are technical difficulties associated with continuous intravenous therapy in infants and young children. With the intravenous as well as by bone marrow a 5 per cent solution of the sodium salt of sulfathiazol in 5 per cent glucose solution or distilled water may be administered, using one half grain per pound every eight hours. With the bone marrow route syringe pressure has to be used because it is difficult to obtain a continuous gravity drip. In the presence of a generalized infection there is danger of localizing the infection in the bone if the needle is permitted to remain in place for a long period of time.

The easiest and best parenteral method of administering sodium sulfadiazine is by subcutaneous infusion. A one half per cent or one per cent concentration in 5 per cent glucose solution may be repeated every six or eight hours depending on the rate of absorption. The total daily dose should be at least one and one half grains per pound body weight for each twenty-four hours. By this method adequate fluids can be given to patients who otherwise would not receive them. When sulfamerazine is used three fourth grain per pound may be given for the first dose then one half this amount every eight hours.²

The foregoing dose schedules will produce satisfactory working sulfa blood levels, providing scrupulous attention is paid to the fluid intake. It does not however relieve the doctor of the responsibility of watching his patient carefully. With slight infections that respond quickly, treatment may be discontinued within twenty-four hours after the temperature has returned to normal. In the severer infections the dosage may be reduced but the drug continued for three to ten days after all signs of the infection have subsided.

The promiscuous use of sulfa in acute colds, grippe, rhinitis, acute pharyngitis, and tonsilitis is not good therapy. Clodfelter has shown that acute tonsilitis recovers as quickly and as well without sulfa as with the drug.

Both good and poor results have been reported with the use of sulfa compounds in the treatment of intestinal infections, mainly with dysentery bacilli. Sulfaguanidine is probably the most satisfactory drug in this group. It is absorbed very poorly from the intestines thus producing high concentrations in the bowel to exert its bacteriostatic effect on the intestinal flora.³ The drug has been used both in the treatment of the acute disease as well as the carrier state. Vitamin K and B should be given to patients receiving sulfaguanidine for long periods because the depressed state of the intestinal flora might interfere with the manufacture and absorption of these vitamins. Sulfaguanidine, three fourth grain per pound body weight, may be given for the first dose, then one half this amount may be administered every four hours. Succinyl sulfathiazol and sulfathalidine may be used as substitutes for sulfaguanidine.

The external application of sulfonamides had quite a vogue which fortunately has waned. An aqueous solution was used in the eyes with good results. However, penicillin solutions have supplanted it. Sulfa nose drops or sprays were used without much success. One can readily understand this result when we consider that sulfa is only bacteriostatic for the reproducing organism and most remain in contact with the organism for some period of time, one or two hours at least. Many cases of sensitization to the drug develops through the repeated local use in the nose. Sulfa ointment was used on burns with the assumption that it would prevent secondary infection, but it was learned that the systemic use was to be preferred. Many local reactions to the drug appeared. Sulfa ointment does clear up superficial skin infections, notably impetigo. However, we must not forget that ammoniated mercury ointment was almost specific for this condition before the advent of sulfonamides. Sulfa ointment has also been used on newborns as a prophylactic with good results and very few reactions.

Toxic effects and reactions may follow the use of sulfonamides depending upon the type of drug used as well as the susceptibility of the patient. Sulfadiazine and sulfamerazine show the lowest percentage of reactions. Nervous symptoms are frequently encountered and may vary from mild lassitude, anorexia, nausea or vomiting, to frank psychosis. Nausea and vomiting are produced by central nervous irritation. Blood disturbances are occasionally seen after prolonged medication. A depression of the bone marrow exemplified by a low white

count, decreased granulocytes and finally a low grade anemia, follow in order. When the white count reaches 4,000 the drug should be discontinued.⁴ Neither of these conditions is serious if recognized early. After discontinuing sulfa, appropriate therapy to restore the blood to its proper level should be started. Any sudden rise of temperature during the course of a sulfa treated patient, especially if it happens after a day or two of normal temperature, should make one suspect sulfa as the exciting cause, particularly if the temperature returns to normal when the drug is withdrawn. This is not an uncommon occurrence.

Drug sensitivity may produce skin eruptions early or late in the course of treatment; a macular or papular erythematous rash is the usual type of eruption.

Kidney complications can be the most serious of all the sulfa reactions if the urine is not checked often and thoroughly. The pure and acidulated form of sulfa is filtered through the glomerulae in solution. In the tubules the solution is concentrated by resorption of water. If the concentration of the drug is high, precipitation occurs and sulfa crystals appear in the urine. This is the first sign of trouble and should call for a large increase in the patient's fluid intake. Parenteral fluid should be given if necessary. If the urine is acid the precipitation will be greater. The addition of alkalis will decrease or prevent this precipitation if given in large quantities. One cannot stress too much the need for a large fluid intake, at least two or three quarts daily, when administering sulfonamides. Alkalis will not be necessary if there is sufficient fluid to produce a large kidney output. If attention is not paid to sulfa crystals in the urine, red blood cells will be next to appear, followed shortly by frank blood and later tubular obstruction with sulfa calculi. When the kidneys become involved there is usually pain in the upper abdomen, both flanks and back in the kidney region.

Lehr has recently made some observations and suggestions that may materially reduce the number of kidney complications thus making the administration of sulfa drugs safer.⁵ He was able to show that aqueous solutions saturated with sulfadiazine would dissolve equal, additional quantities of another sulfonamide. Applied clinically this would mean that if sulfadiazine and sulfathiazole were administered in equal amount, appreciably larger doses of the combined drugs compared with a single drug would be tolerated before crystals appeared in the urine. There have been confirmatory clinical observations to substantiate this claim. However, we have found crystals in the urine of many children on this mixed drug routine. Before discarding the one drug therapy further clinical trial is necessary.

Sulfonamides have been used as prophylactic

measures against such diseases as rheumatic fever,⁶ meningitis, dysentery, and upper respiratory tract infections. The best and most complete work has been carried out against rheumatic fever. When the rheumatic fever had completely subsided, the patients were placed on sulfadiazine .5 gm. once or twice daily depending upon their age, in hopes of preventing infections with hemolytic streptococci. The results of the studies have been excellent but the program should be carried out for a longer period before being accepted as a safe prophylactic therapy.

Several objections to the prolonged administration of sulfonamides must be considered. First, there is the possibility of sensitizing the patient to the drug so that he will not tolerate treatment doses. Secondly, there is danger of producing sulfa resistant strains of Streptococci. This was demonstrated in the Navy and Air Force program. The first year was very successful but when the program was carried longer the sulfa resistant strains upset the prophylactic program.⁶ Thirdly, after years of sulfa therapy, patients may become hypersusceptible to infection when the drug is withdrawn; fourthly, the drug may have some effect on growth and development, a theoretical point that has not been investigated; and last, toxic symptoms of drug poisoning may develop at any time during the course of treatment. This necessitates the frequent examination of blood and urine. The urine should be examined at least once per week. A white blood count and hemoglobin determination must be done every second week for the first eight weeks, then at least once per month thereafter. At the first sign of bone marrow depression the drug must be omitted.

When small doses of sulfonamides are administered to contacts, for short periods of time not to exceed one week, in diseases like meningococcus meningitis, scarlet fever and dysentery, no extra precautions need to be observed other than the usual follow-up care.

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Sodium Restriction in Hypertension

There is an old saying that no matter what a doctor does or does not do for a patient, the patient should feel the better for having seen the doctor. In chronic disease of any type, the avoidance of creating fear in the mind of the patient, the avoidance of unnecessary limitation or invalidism, cannot be overemphasized. Before embarking on any rigid medical or dietary program for the hypertensive subject, we are obligated to examine the evidence critically. Treatment should not be carried out just in order to do something, but should always have some reasonable justification. We should not treat the elevated blood pressure without regard for the patient who has it, or without an understanding of the highly variable natural history of the disease.

Let us look at the evidence that sodium chloride bears some relationship to hypertension. Restriction of salt intake as a therapeutic measure in hypertensive vascular disease was first advocated many years ago by Volhard, Ambard, Allen, and others. Although subsequent investigators claimed that the addition or removal of salt from the diet failed to alter the blood pressure significantly, interest in the subject has been recently renewed. Selye and his co-workers noted a striking hypertensive effect when sodium chloride was administered to experimental animals receiving injections of desoxycorticosterone acetate. Grollman and his associates observed that drastic reduction in sodium intake resulted in a decline in blood pressure in some hypertensive patients. They believed it probable that the beneficial effects of the diet proposed by Kempner might be due to restriction of salt. Recently Knowlton and her collaborators presented evidence that sodium chloride potentiates the pressor activity of desoxycorticosterone acetate when injected into experimental nephritic animals.

It appears that sodium chloride is related in some way to the mechanism of hypertensive vascular disease. Its restriction as a therapeutic measure is still on a trial and experimental basis, the harm of such limitation and dietary invalidism often exceeding the benefit. It remains to be seen as to the effects of rigid salt restriction on the natural history of the disease.—George A. Perera, M.D., New York City. *Connecticut State Medical Journal*, Vol. XI, No. 12, December, 1947.

Propylthiouracil and Methyl Thiouracil in the Treatment of Hyperthyroidism

E. PERRY McCULLAGH, M. D., and ROBERT W. SCHNEIDER, M. D.

THE standard method of treatment of hyperthyroidism, whether associated with the diffuse goiter of Graves' disease or with adenomatous goiter, has for many years revolved about one principle, the surgical removal of a sufficient mass of thyroid tissue to bring the total force of thyroid activity within normal range. In adenomatous goiter this method produces an effect which, while obviously not physiologic, in most cases may be considered a cure. Recurrences following this procedure in adenomatous goiter are rare. In Graves' disease the fundamental nature of the condition is unknown, and hyperthyroidism is only one part of the syndrome. The hyperthyroidism in itself is usually controlled by removing the major part of the thyroid tissue. The other features of the disease usually tend to subside postoperatively. They do not always do so, however. Apart from the hyperthyroidism the eye changes are the only features of Graves' disease subject to measurement. The fact that exophthalmos may appear and advance to severe proportions long before or long after the presence of hyperthyroidism, or in some cases in which hyperthyroidism never appears, clearly indicates that the disorder depends little if at all on thyroid activity, and there is no explanation for the frequency of postoperative cures. A fact commonly overlooked is that remissions of varying duration or complete disappearance of the disease occurs spontaneously; therefore a completely accurate record of the results of operation in Graves' disease can not be determined. Postoperative recurrences of hyperthyroidism are common, being variously estimated between 5 and 18 per cent.

Since the advent of the use of large doses of iodine preoperatively in thyroid surgery the mortality has been greatly reduced. Otherwise iodine has changed the general problem little, though it may be useful in a few instances as a long-continued treatment in very mild hyperthyroidism without operation or in mild postoperative recurrences.

Though thyroidectomy is up to the present time the most certain cure of hyperthyroidism, it carries with it certain disadvantages which include an operative mortality rate of about one per cent, loss of time, cost of operation and hospitalization, the chance of recurrence in Graves' disease, as well as the morbidity which

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follows injury to the recurrent laryngeal nerves, and the lasting inconvenience of chronic parathyroid tetany in the occasional patient.

Radiation therapy has never held a very important place in the treatment of hyperthyroidism. Its greatest usefulness in most hands has been in the treatment of patients unsuitable for operation because of the increased morbidity in postoperative recurrences or in severely ill patients with a prohibitive surgical risk. This situation may be changed greatly by the new method of irradiation therapy from within the gland by radioactive iodine. Judging from the first few patients reported,^{1,2} the method is promising, but much remains to be learned. The cost of treatment, practical methods of distribution of the radioactive material, methods of estimation of proper dosage, the risk involved both as to possible excessive damage to the thyroid and surrounding structures and to distant parts are among problems which need to be evaluated.

Thiouracil and its derivatives have offered a somewhat more physiologic attack on hyperthyroidism than surgery and have raised the hope of a safe medical cure. It is true that in Graves' disease thiouracil does not appear to strike any closer to the cause than surgery does, but even with this in mind it has not seemed illogical to hope for cures brought about in much the same way as those which follow thyroidectomy.

Physiologically the thiourea compounds have their chief action within the thyroid cell. It is believed that this action takes place through a specific effect upon the enzyme system necessary for the conjugation of iodine and the

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proteins necessary for the formation of iodothyroglobulin. These substances delay metamorphosis in tadpoles and produce cretinism in animals. Animals which are fed thiourea compounds develop goiters showing pronounced hyperplasia of the acinar epithelium and absence of colloid. Such changes within the gland are dependent on the production of thyrotrophic hormone, and the response can be prevented by thyroxin³ or by hypophysectomy.⁴ In animals such changes occur in a few days.⁵ As they progress and the stored thyroid hormone disappears from the body the basal metabolic rate falls, and the signs of thyroid deficiency become apparent within two or three weeks.

The drug is very rapidly absorbed from the stomach and duodenum, and much of it is quickly eliminated in the urine.⁶ The fate of the remainder is unknown.

The thyroid glands of thiourea-treated animals fail to take up iodine in the normal manner,⁷ and in man such glands apparently have less than the normal curative effect on myxedema.⁸

THE EFFECTIVENESS OF THIOURACIL

Before thiouracil was placed on the market it had been used in the treatment of more than 5,000 patients with hyperthyroidism. It was proved abundantly to be an effective means of controlling any type of hyperthyroidism with the possible exception of severe crises in which its action was too slow. Hyperthyroidism of acromegaly may also prove to be an exception.

The rate of response to the drug is not easily predicted. A fall in basal metabolic rate of one per cent per day is seldom exceeded, while at the opposite extreme some patients fail to show any response of consequence for four or five months but later are well controlled. In general the small diffuse gland responds quickest and the large nodular goiter slowest. The prolonged use of iodine preceding thiouracil therapy is a barrier to prompt response. One of the chief advantages of this therapy is the complete control of hyperthyroidism, and almost all patients are able to follow their usual occupations. Complications are controlled as well by thiouracil as by thyroidectomy.

The main disadvantage of thiouracil is that toxic effects such as fever, rash, or nausea occur in 10 to 15 per cent of the patients. Much more serious is the agranulocytosis which has been seen in 2 to 3 per cent and death from this occurs in $\frac{1}{2}$ to 1 per cent. In addition, a striking enlargement of the thyroid has occurred in some patients. These effects have prevented the use of the drug in many cases. The mortality rate from this drug is comparable to that of thyroidectomy in the hands of the most skillful surgeons. Thiobarbital, which is much

more potent in its antithyroid action, has similar toxic effects.

The rate of permanent remission of hyperthyroidism with thiouracil therapy has not been determined. One of the best estimates is that of Williams,⁶ who reported a remission rate of 50 per cent in 100 cases. It is possible that the general tendency toward early withdrawal of the drug because of the risk of toxic effects may have reduced the number of permanent recurrences.

PRESENT USEFULNESS OF THIOURACIL

Since thiouracil is no safer than surgery in the average case and since it has not been proved that it will cause remissions as often as will thyroidectomy, its greatest benefit is the reduction of surgical risk in selected patients. If it is used in severely toxic patients, those with cardiac failure, those who are weak from longstanding disease, or in the aged, many will become good surgical risks. In those who remain bad risks continued therapy may be warranted. By using thiouracil in this way the mortality of thyroid surgery has been reduced almost to the vanishing point.

PROPYLTHIOURACIL

It is evident that a safer drug than thiouracil is needed, and 6-n-propylthiouracil appears to have supplied this need. Our experience covers the treatment of 218 patients over a period of fifteen months from December, 1945, to March, 1947.

SAFETY OF PROPYLTHIOURACIL

Astwood⁵ in the first 100 cases reported found four instances of transient pruritus, two of transient headache, and one of transient arthralgia. One patient died during therapy apparently from progressive hepatic failure due to extensive cirrhosis.

In our patients mild toxic effects occurred in five. Their symptoms were transient, disappearing during continuation of the drug. One patient had nausea and hives on 200 mg. per day but could tolerate 100 mg. One patient had nausea while receiving 300 mg. per day but tolerated 200 mg. Two patients described mild numbness which could not be readily explained on the basis of hypothyroidism. One other patient had a transient mild arthralgia suspected to be due to the drug. The drug has been stopped in three patients and thyroidectomy advised partly or solely because of symptoms suspected to be due to the drug. In the first, leukopenia and sore throat occurred on two occasions, disappearing the first time on withdrawal of the drug. The second time there was a drop of granulocytes to 25 per cent and soreness of the tongue. Because of the anxiety of the patient as much as

the severity of the symptoms operation was recommended. The dose she had received was 75 mg. per day for fourteen weeks and 150 mg. per day for eight weeks. The second patient complained of numbness of the extremities. The neurologic examination has been normal and the symptoms have persisted for four months after thyroidectomy and the cessation of the drug. This probably has been a toxic effect, but further observation may lead to recognition of an unrelated organic central nervous system lesion. The dose used was 200 mg. per day for six weeks, then 300 mg. per day for four weeks. The third patient took thiouracil in doses of 0.2 to 0.5 gm. per day for six months. Six weeks after withdrawal of treatment the symptoms recurred. Propylthiouracil was then given in doses of 50 to 75 mg. per day for ten months. Two weeks after the dose was increased to 150 mg. per day a severe dermatitis appeared and the drug was stopped. Four months following withdrawal of propylthiouracil a recurrence of the dermatitis appeared. Our dermatologists* believe this dermatitis was due to propylthiouracil. One patient, 64 years of age, died after a day of vomiting while taking propylthiouracil. He had no fever so that agranulocytosis was unlikely. As he lived at a distance, no diagnosis was reached and no autopsy was done. It seems unlikely that this death was due to propylthiouracil, but the possibility must be considered.

Toxic effects in our patients have required withdrawal of the drug in 1.5 per cent. Because of the uncommonness of toxic effects we do not consider frequent white blood counts necessary and they are only done in case of fever, sore throat, or suspicious symptoms.

EFFECTIVENESS OF PROPYLTHIOURACIL

The effectiveness of propylthiouracil in the smaller doses used a year ago was frequently slower than that seen with thiouracil. More recently with larger doses the effect has been approximately the same as that with thiouracil. A fall in basal metabolic rate of more than one per cent per day is considered very unusual. In some patients increased dosage has not produced evidence of a fall in the basal metabolic rate for several months. In all patients without serious complications the symptomatic control paralleled a fall in basal metabolic rate, and although patients have been seen with clinical evidence of hyperthyroidism when the basal metabolic rate has not fallen below +10 per cent symptoms have always disappeared before the metabolic rate has reached -10 per cent. It has been observed repeatedly that the rate of

fall of basal metabolism was rapid at first and tended to be much slower as the normal range was approached. Our practice recently, therefore, has been to decrease the dose only when a completely normal basal metabolic rate has been maintained for six to nine months. If signs of hypothyroidism make their appearance earlier than this, the drug is continued and desiccated thyroid is given in addition to overcome the hypothyroidism while continued pressure is maintained upon the patient's own thyroid gland.

PROPYLTHIOURACIL DOSAGE

Because of our experience with the toxic effects of thiouracil the tendency in the use of propylthiouracil has been a cautious approach to the minimum effective dose. An analysis of our data indicates that if we consider "effectiveness" an average fall of 2 per cent per week in basal metabolic rate to a time when a normal range is reached, the following results are obtained:

150 mg. per day or less—42 per cent ineffective.

200 mg. per day or less—12.6 per cent ineffective.

300 mg. per day or less—3.7 per cent ineffective.

In each category all cases responding to smaller doses are added to those requiring and responding to the dose listed in the next range above it.

Up to the present, 400 mg. per day has been "effective" in all except one, a patient who had acromegaly. In 16 patients who received a dose below 150 mg. per day the basal metabolic rate fell from an average of +23.5 per cent to normal in thirteen and six-tenths weeks, an average fall of 1.73 per cent per week. In 71 patients given a dose of 150 mg. per day or more the basal metabolic rate fell from an average level of +38 per cent to normal in thirteen and six-tenths weeks, a fall of 2.82 per cent per week. In some the basal metabolic rate has lagged at a level of approximately +20 per cent. In calculating the above data, when it appeared reasonable to us to do so, such patients are excluded from our calculations because the basal metabolic rate has been influenced by such conditions as asthma, tracheal obstruction from goiter, or dyspnea associated with cardiac decompensation or arterial hypertension.

In all, 34 per cent of our patients have received a dose of 300 mg. or more. Our present tendency is to use 200 mg. or more per day as a beginning dose in mild cases, 300 mg. or more in those with moderate and severe disease.

The response in nodular and diffuse goiter on the whole differs little. The average response in 22 patients with nodular and 51 with diffuse

*This case is described by Dr. George H. Curtis in the *Cleveland Clinic Quarterly*, 14:276-281, Oct., 1947.

goiter shows the latter to respond in reduction of basal metabolic rate faster by 0.5 per cent per week. This difference is chiefly by virtue of the fact that a few very slow responses occur in nodular goiters.

It has been found convenient on repeated occasions to use small doses of iodine to eliminate the thrill and bruit which appeared over a diffuse goiter in the course of therapy. We wondered whether the use of 20 or 30 mg. of iodine per day for this purpose influenced the effectiveness of propylthiouracil to any marked degree. Groups of patients with diffuse goiter have therefore been used for comparison, approximately half being given 300 mg. per day of propylthiouracil without iodine and half being given propylthiouracil plus 20 mg. per day of iodine. There was very little difference evidenced. It can be said that this much iodine did not retard the effect of propylthiouracil.

PRESENT USEFULNESS OF PROPYLTHIOURACIL

Until such time as it is proved that propylthiouracil has in addition to a factor of safety the power of causing a long remission in hyperthyroidism equal to that of surgery, its chief value will remain the reduction of surgical risk to a minimum in selected cases.

At present we believe for the most prudent use of propylthiouracil, patients may be considered in four groups.

Group I. In mild or moderate hyperthyroidism without large goiter^{*} propylthiouracil may be used in an attempt to produce a medical cure. If this is done it is our belief that a basal metabolic rate within normal range or slightly below should be maintained for six months or more. Such patients are all told that a permanent cure can not be promised and are warned to report sore throats or any untoward symptoms, but blood counts are not done routinely. In cases where signs of hypothyroidism appear we prefer to give desiccated thyroid and to continue propylthiouracil. This plan may be abandoned for several reasons: (1) The patient may prefer surgery. (2) She may be unintelligent or uncooperative. (3) Toxic effects may interfere. (4) Future experience may prove that it is preferable to diminish the dose of the drug as soon as control is obtained and to withdraw it gradually if hyperthyroidism does not recur.

If after a reasonable time withdrawal of the drug is followed by recurrence of hyperthyroidism the choice between surgery and long-continued use of propylthiouracil must be made. This drug is also recommended in all cases of postoperative recurrence.

Group II. In all young people with hyperthyroidism of mild or moderate degree when there

is no apparent risk to surgery and when thyroidectomy is decided upon, iodine preparation without propylthiouracil may be the pre-operative treatment of choice. It may be used but is unnecessary.

Group III. Complete control of the disease with propylthiouracil is advised in all patients with severe hyperthyroidism, in all those over 45 years of age, as well as those with complicating factors such as poor cardiac status. When the disease is thus controlled Lugol's solution is given for two weeks in doses of 1 cc. three times a day. During the second of these two weeks no propylthiouracil is given and thyroidectomy is performed.

Group IV. In patients whose hyperthyroidism is complicated by extreme old age, by cardiac or other complications which will prevent their ever becoming good surgical risks even after the elimination of hyperthyroidism, propylthiouracil may be continued indefinitely. To this group may also be added those patients with postoperative recurrence of hyperthyroidism, because in them the increased morbidity from nerve or parathyroid gland injuries warrants withholding further operation unless it becomes imperative.

Nothing substantial can be said as yet about the final estimate of recurrence rate. Inadvertent discontinuance of the drug during the early months of treatment has been followed by prompt exacerbation.

METHYL THIOURACIL

Methyl thiouracil has been used in several hundred cases abroad, chiefly in Sweden, Denmark, and England. Thyssen⁹ has reported 28 patients, and Wilson 30 patients.¹⁰ Barfred¹¹ has treated 61 cases.

Toxic reactions have been relatively frequent in the patients treated abroad. This may be associated with the fact that large doses sometimes up to 1.0 gm. per day and at times over 2.0 gm. per day have been used.

Our experience with this drug has been with 24 patients treated for periods up to four months. We have used smaller doses than the Europeans, starting usually with 200 mg. per day. Larger doses have been given in nine. Three hundred mg. per day have been used in eight, 400 mg. in one. No toxic effects of any kind have been seen to date. We have been impressed with the fact that the drug has been very effective. In all but one of the 16 patients followed long enough to form a fair estimate, the response has been considerably more rapid than with propylthiouracil. The average response to the methyl form has been a fall of basal metabolic rate of 4.6 per cent per week in 16 patients as compared to an average response to

propylthiouracil of 2.8 per cent per week in 71 patients.

SUMMARY

1. Propylthiouracil is a safe and effective method of control of hyperthyroidism.

2. It is much safer than thiouracil.

3. Its chief usefulness at present is to accomplish the complete elimination of hyperthyroidism in the poor risk patient so that surgery may be performed safely.

4. It is useful also in the treatment of all patients with recurrent postoperative hyperthyroidism. In these the use of propylthiouracil indefinitely may be advisable.

5. The use of propylthiouracil may be advisable for indefinite terms, also in extreme old age and under circumstances in which elimination of the hyperthyroidism present is not sufficient for the production of good surgical risk.

6. In patients with small goiters and mild to moderate hyperthyroidism a permanent medical cure with propylthiouracil may be attempted.

7. Methyl thiouracil offers a highly effective means of controlling hyperthyroidism. Its toxicity in large doses has been relatively high, with smaller doses not established.

8. The rate of permanent remission of hyperthyroidism following propyl or methyl thiouracil therapy is not known.

Our thanks are due to Dr. Stanton Hardy and the Lederle Company for generous supplies of 6-n-propylthiouracil and to Dr. K. W. Thompson and Roche-Organon for the methyl thiouracil used.

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KEEPING UP WITH MEDICINE

● WHILE a virus is one cause of colds, it is not the only cause. The weather is somehow concerned.

* * *

● IN the last twenty years, we have at last got scientific standards for diet (amateur though they be). We know now that malnutrition is responsible for a great many deaths of babies and women in childbirth.

* * *

● AT present the sewage of our cities does not get back to replenish the soil whence it was taken. Sanitarians will soon be compelled to give attention to this.

* * *

● AT the beginning of the nineteenth century, it was commonly held that tuberculosis was the result of a hereditary predisposition.

* * *

● THE scientific basis for calling certain posture good is that, when the muscles and bony structure are held in that position, the weight will be so distributed as to be supported easily and without strain; while the organs will also be kept in the places where nature intended them to be and where they can function best with the least effort.

* * *

● ALL of us should pay more attention to the tragedy of the unbalanced diet.

* * *

● FLUORINE has more combining power than oxygen and kills by precipitating the whole blood calcium.

* * *

● ESTROGEN treatment for cancer of the breast must be confined to women of 60 years or older (no ovarian output), but male hormones may be given to women of any age with breast cancer.

* * *

● COMPLEMENT has been dubbed the "Diagnostic Drudge".

* * *

● THE methods of genetics, which are biological—not chemical—must supplement those of chemistry if the chemist is to understand what the organism does chemically.

* * *

● NEW carcinogens are constantly coming into recognition, and this will continue to happen because the shifting circumstances of modern life involve exposure to conditions having end results which cannot be foreseen.

* * *

● IMMATURE growing animals are more difficult to make diabetic by anterior pituitary extracts than older ones.

* * *

● GREEN and yellow vegetables are always a good buy from the vitamin A and C and caloric point of view.—J.F.

Thrombocytopenic Purpura Hemorrhagica

C. R. RITTERSHOFER, M. D.

THROMBOCYTOPENIC purpura hemorrhagica is judged to comprise a group of closely related hemorrhagic diseases characterized by

- (1) A marked reduction in the number of circulating platelets.
- (2) A prolonged bleeding time.
- (3) A decrease in capillary resistance.
- (4) Spontaneous frank bleeding from mucous membranes and bleeding into the skin causing petechiae and ecchymoses.

A simple classification¹ of purpura is outlined below:

I Diminished blood platelets (thrombocytopenia)

- A. Primary (Essential or idiopathic)
 - a. Acute.
 - b. Chronic.
- B. Secondary
 - a. Infection.
 - b. Blood dyscrasias.
 - c. Allergy (Drugs; foods).
 - d. Toxins.
 - e. Diseases of the liver and miscellaneous.

II. Normal platelet count.

- A. Simple
 - a. Senile.
- B. Anaphylactoid (Schönlein-Henoch)
- C. Nutritional.
 - a. Vitamin C deficiency.
 - b. Vitamin P deficiency (?)

Only the thrombocytopenic purpuras are primarily hemorrhagic diseases. It is probable that anatomic alterations of the smaller vessels often account for the ecchymotic lesions observed in the non-thrombocytopenic forms of purpura, especially true of the senile and scorbutic types. The Schönlein-Henoch type is now regarded as anaphylactoid in nature, but no adequate explanation has been offered why the platelets are not reduced in this disease, while they often disappear precipitously in allergic thrombocytopenia.

Poncher² states that purpura is the most variable symptom in the Schönlein-Henoch syndrome and he believes that in this clinical entity one is dealing with a general or systemic process exhibiting a variability of skin changes and visceral manifestations. He believes that the syndrome should be looked upon as a generalized disease presenting a variable clinical picture with purpura as a common but by no means constant sign.

Cases with a normal platelet count but a prolonged bleeding time should be classified as pseudo-hemophilia and not Werlhof's disease.

¹Read before the Section on Pediatrics at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947.

The Author

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There is nothing in the literature to suggest any constitutional or hereditary influence. Age of onset in children is not definitely known although cases have been reported in the newborn.

SIGNS AND SYMPTOMS

Hemorrhage into the skin is one of the most outstanding findings. Often the first intimation is a ready tendency to bruise from slight trauma. In children especially, areas overlying bony structures such as the tibia, the crest of the ilia, the knees and the elbows are often the sites of the first appearance of purpura. The eruption varies from petechiae to multiple ecchymoses. The purpuric lesions do not fade when compressed. Petechiae consist of dilated capillaries situated directly under the epidermis with relatively little free hemorrhage into the surrounding tissue, whereas free hemorrhage produces the ecchymotic spots. In the absorption of this extravasated blood typical color changes are produced—the initial reddish blue color deepens, then fades and becomes a light tan before it disappears. The intradermal bleeding unlike that of hemophilia rarely leads to any complications.

Hemorrhage may occur from any, or at times from almost all mucous membranes. In children the peridental gingival margins are the most frequent sites of bleeding in the mouth. Epistaxis may be very troublesome. Bleeding from the tongue and tonsils may occur. The gastro-intestinal tract may be involved but the occult blood in the stool and hematemesis can often be traced to swallowed blood coming from oral or nasal bleeding. Bleeding from the urinary tract is observed, but is not as dangerous as the hematuria of hemophilia. Menorrhagia is one of the most common and persistent forms of hemorrhage in women. Among the most dreaded types of hemorrhage are the intraocular and cerebral. Bleeding into the vitreous and into the retina may lead to permanent impairment of vision. Cerebral hemorrhage is perhaps the most

important cause of death, and is evidently more common than is death from exsanguination.

Usually it occurs late in the disease and is more frequent during an acute attack. A case has been reported by Gitt and Weiss in which a subarachnoid hemorrhage was the first manifestation of the thrombocytopenic purpura. Hemorrhage into the basal ganglion may cause fever, convulsions, and other neurological disturbances.

COURSE

Elliott has summarized the situation in childhood as follows: In childhood, idiopathic thrombocytopenic purpura tends to be a self-limited disease, characterized by spontaneous recovery. In relatively few instances does it persist into adulthood as a chronic recurrent ailment.

THE DEFECT IN THROMBOCYTOPENIC PURPURA HEMORRHAGICA

The disease has two constant and outstanding characteristics, (1) a reduction in the number of circulating platelets, and a pronounced bleeding tendency and (2) the two main organs affected are the spleen and the bone marrow. The question that confronts all investigators is how these factors are inter-related and the role that each one plays. The possible cause of the decrease in platelets may rest in the spleen. One group of workers believes that the thrombocytopenia is brought about by a hyperactivity of the spleen in destroying platelets, and has suggested the name "thrombolytic purpura". In favor of this view is the marked benefit obtained by splenectomy. Occasional failures have been explained as due to the presence of accessory spleens. On the other hand the platelet count may remain low even though the bleeding tendency is abolished or greatly decreased. Thrombocytopenia can occur in the absence of the spleen.

A SPLENIC PLATELET DEPRESSING FACTOR, THROMBOCYTOPEN

In 1938, Troland and Lee⁴ reported that they had prepared from thrombocytopenic spleens—an extract which, when injected into rabbits, caused a marked reduction in the platelets and a great increase in the bleeding time. Extracts from control spleens failed to produce these results.

Other observations by Davidson⁵ and Sanford⁶ describe babies born of mothers with purpura hemorrhagica, who at birth or shortly after developed purpura and had a low platelet count. All these infants promptly recovered, and had no recurrences of the purpura, thus making it appear likely that a toxic factor from the maternal organism was responsible.

Bone Marrow. Frank has stressed the view that the cause of chronic thrombocytopenic purpura is in the bone marrow, a toxic depression of the platelet mechanism. This view is based

on the observation that all factors which depress the bone marrow bring about a fall in platelets. Thus, agents such as benzol, Röntgen rays and radium, bacterial toxins, and neoplastic metastases all produce a reduction in platelets. The evidence against the bone marrow as a primary factor in the disease is based on the relatively normal microscopic appearance of the bone marrow.

The relation between the number of platelets and the bleeding tendency. Since a severe thrombocytopenia is almost invariably the striking finding in hemorrhagic purpura, one is apt to conclude that the bleeding is directly dependent on a deficiency of platelets. But a study of purpuric cases shows that some patients bleed at a platelet level of 60,000 or higher while others may show only mild purpura with 20,000 platelets per c. mm. or less.

Roskam found that by injecting gelatin intravenously into dogs, the platelets were reduced to very low levels, with little or only a slight increase in the bleeding time. Bedson using a solution of agar in serum produced similar results. On the other hand the use of an anti-platelet serum by many workers produced not only a thrombocytopenia but a purpura resembling Werlhof's disease. To explain this difference Bedson first tested the action of an anti-red blood cell serum. No reduction in platelets, no bleeding tendency, nor any decrease in capillary resistance was obtained. But by first injecting the anti-red blood serum and then the agar serum, not only were the platelets reduced, but the bleeding time was prolonged and the capillary resistance as shown by the purpura was reduced. Bedson explained his results by postulating that the anti-red cell serum produced capillary damage and that the combination of this vascular injury and platelet deficiency caused the purpuric picture. Two conditions therefore must be present for purpura hemorrhagica to develop: a vascular defect or injury, and a depletion of platelets.

Elliott and Whipple who have confirmed Bedson's results, conclude: "From our clinical as well as from our experimental work, we feel that we have definite evidence of the existence of capillary and platelet factors in the mechanism of the disease. Emphasis has gradually shifted from a concept of anatomic capillary injury to excessive vasodilatation. This has necessitated postulating the presence of a capillary toxin or dilator.

Payne and Whiteherd commenting on the marked stanching of bleeding following splenectomy conclude that this suggests the presence in the blood stream of a toxin which tends to lower capillary resistance yet so transient in its effect that a continuous supply is necessary for sustained action. Poncher² has offered the

following explanation: The facts appear to be that platelets have a protective action against the spontaneous occurrence of purpura and hemorrhage but their absence is not a direct cause for such bleeding. The primary cause must be another factor. When this factor is absent, hemorrhage will not occur whether platelets are reduced or not. When this factor is present, the function of the platelet is to act as a protection and condition the severity of the bleeding. Quick has offered the following hypothesis: The causative factor responsible for vasodilatation is histamine; and the function of the platelet is to remove this agent. Thus platelets in carrying out this task are rendered more liable and susceptible to agglutination and lysis. The assumption of a continuous over-production of histamine in hemorrhagic purpura readily accounts for the vasodilatation and hyperpermeability as well as for the reduction of the circulating platelets. Since histamine is widely distributed in the body, it seems logical to assume that whenever vasodilatation occurs this substance is the most probable causative factor. It seems logical that the platelet, rather than supplying histamine, is actually engaged in removing this toxin from the blood.

The histamine theory promises to explain the relation of idiopathic hemorrhagic purpura, and the allergic type. In the former, the over-production of histamine is presumably small but constant, but in the fulminating cases such as is apt to occur in the allergic type the liberation is sudden and overwhelming. Just how the splenic function and histamine metabolism are related is not known.

PATHOLOGY

The chief pathological findings are the purpura, the bleeding from various mucous membranes, and the anemic appearance that follows profuse or prolonged hemorrhage. Slight enlargement of the spleen is often observed, but marked splenomegaly should call for caution in making a diagnosis of primary thrombocytopenic purpura. The reports on the bone marrow have also been at variance. Wiseman, Doan and Wilson⁷ state: "Most observers have found the bone marrow to be normal, which coincides with our experience."

The blood picture. A marked decrease in platelets is the most characteristic finding. In the majority of cases the platelet count is below 50,000. The other hematological changes are for the most part secondary to loss of blood. Leukopenia or the appearance of abnormal white cells should immediately arouse one's suspicion of a blood dyscrasia.

DIAGNOSIS

The clinical features which suggest a diagnosis of purpura hemorrhagica are the petechiae and ecchymotic spots in the skin and the bleeding

from mucous membranes. However, bleeding may occur without any skin manifestations, and also purpura may occur in other diseases in which the platelets are normal. The final diagnosis rests on laboratory findings; reduction in the platelet count, prolongation of the bleeding time, positive tourniquet test, absent clot retraction, a normal or only slightly prolonged coagulation time.

1. Thrombocytopenia. The platelet count is usually below 50,000, but there is no quantitative relationship between the number of platelets and the severity of the hemorrhagic condition.

2. Bleeding time is invariably prolonged. Duke's method is commonly used. A prolonged bleeding time in the absence of thrombocytopenia suggests the probability of pseudo-hemophilia.

3. The tourniquet test measures the capillary resistance.

4. Clot retraction. The ability of the clot to retract is dependent on the number of platelets in the blood. About 70,000 platelets per c. mm. are required for normal retraction. Clot retraction is an indirect measure of a bleeding tendency.

5. Coagulation time. The clotting time is normal. One can differentiate this disease from hemophilia by this test alone.

6. Prothrombin. The prothrombin level is normal.

DIFFERENTIATION OF PRIMARY FROM SECONDARY THROMBOCYTOPENIC PURPURA

Every diagnostic aid is necessary to accomplish this including a careful history, a thorough physical examination, accurate laboratory tests. Acute leukemia and aplastic anemia may be confused with thrombocytopenic purpura, especially if the pathologic picture is not fully developed. The appearance of myeloblasts or lymphoblasts of course suggest the possibility of a leukemia. When there is doubt, sternal bone marrow examination should leave no further doubt for a striking increase in immature leukocytes will be found, if leukemia is present. In the case of aplastic anemia very little if any regeneration of the blood elements occurs.

In secondary purpura hemorrhagica, infection plays an important role, especially in children. Careful search for foci of infection, teeth, tonsils, sinuses, adenoids is an important part of the diagnostic effort. Metastases to the bone marrow cause a reduction in the platelets. Toxic agents such as benzol, arsphenamine, and allergic sensitivity may do the same, so a careful inquiry as to foods and drugs should be obtained.

TREATMENT

The task of evaluating therapeutic measures fairly and impartially in a disease with remissions and exacerbations; as thrombocytopenic purpura, is difficult, because many secondary purpuras are apt to be diagnosed as primary;

and in these spontaneous recovery usually ensues as soon as the causative factor is removed or exhausted.

Removal of foci of infection. All foci of infection must be eliminated particularly in children, because of the frequent association of purpura and infection. The presence of petechiae should not be a contraindication to the use of sulfonamides.

Splenic irradiation. Conflicting reports concerning the efficacy of this treatment are found in the literature.

Snake venom. The use of moccasin snake venom has received much attention. Here again the value of this form of treatment has stirred up conflicting reports.

Transfusions. According to Kato repeated transfusion of blood is the most effective treatment of acute hemorrhage in idiopathic purpura hemorrhagica. Transfusion just before splenectomy is now the almost universal surgical practice. Wiseman and his associates advise giving full amounts and repeating as often as necessary. Quick states that transfusion often may be as effective as splenectomy, and in all secondary hemorrhagic purpuras, it remains the most trustworthy form of therapy.

Vitamin C. Vitamin C can only be effective in those instances of capillary bleeding where there is a victim C deficiency. No such deficiency exists in the vast majority of thrombopenic purpuras.

Hypercalcemia. In evaluating hypercalcemia as a therapeutic fact one must bear in mind that all the reported cures were in children and thrombocytopenic purpura in young children in the majority of cases is self-limited.

SPLENECTOMY

For adults removal of the spleen is the only one therapeutic procedure which has consistently given effective and usually permanent results. In a series of children described by McLean and his co-workers, they found that spontaneous remissions occurred in a large percentage of cases, that transfusions often accelerated remissions, and that while splenectomy caused the most rapid remission it was not uniformly successful. They also point out that there is considerable operative risk. Splenectomy should be reserved for those with fulminating uncontrollable hemorrhage, and those with chronic hemorrhage. In view of such observations one must conclude that splenectomy in children must be considered as a therapeutic procedure of last resort. Since severe hemorrhagic purpura often follows an acute infection, and since in this type spontaneous recovery is the rule, the need of a careful history and a thorough physical examination cannot be stressed too much. There is no justification for subjecting a patient to splenec-

tomy before the three most common causes of secondary purpura, viz., infection, blood dyscrasias, and allergy, are ruled out.

The procedure followed by Wiseman and Doan¹⁹ is as follows:

1. The diagnosis must be confirmed in all cases by bone marrow examination.
2. Blood transfusions are always given immediately if active bleeding presents.
 - (a) If this is effective in stopping hemorrhage after a reasonable trial, delay in advising splenectomy is justified. If the platelet level, determined daily rises and continues to rise, plans for splenectomy may be temporarily or permanently abandoned, depending on subsequent improvement.
 - (b) If blood loss persists in acute cases in the same or increased volume, splenectomy is not postponed further.
3. Splenectomy is indicated:
 - (a) Chronic cases if free bleeding persists after a reasonable period of treatment with transfusions or when social or economic factors are important.
 - (b) Acute cases when transfusion is not immediately effective.
4. Splenectomy is contraindicated in:
 - (a) Cases of doubtful diagnosis;
 - (b) Cases presenting a recent history of contact with certain drugs.
 - (c) Cases occurring during the active or convalescent stages of all infectious diseases.
 - (d) Cases in which the bone marrow shows depletion of the megakaryocytic content of the bone marrow.

Wintrobe states that splenectomy is safer in the quiescent stage. In the first episode of bleeding, especially in children, it is more probable that bleeding will subside spontaneously rather than become more severe. In chronic or recurrent cases splenectomy is advisable if growth or development is delayed, even if the hemorrhage is only moderate in character.

Following splenectomy the platelet count may increase rapidly, within 24 or 48 hours, and may reach very high levels in about ten days. The high platelet count subsides, however, and sometimes thrombocytopenia may even develop again. Wintrobe reports that hemorrhage of moderate or even marked degree may occur if thrombocytopenia recurs, but that thrombocytopenia following splenectomy is the exception rather than the rule.

All infants born alive to mothers with thrombocytopenia should be blood typed immediately, and the bleeding time and a blood platelet count should be made. The treatment of hemorrhagic purpura in newborn infants is the same as in anyone else, namely, repeated small transfusions.

SECONDARY THROMBOCYTOPENIC PURPURA

The important question to be answered in this group is: What causes the great decrease in the platelet level and the marked bleeding tendency?

The two most important means by which thrombocytopenic purpura is produced are: first, depression of bone marrow activity; and second, excessive destruction of platelets.

BLOOD DYSCRASIAS

In acute lymphatic leukemia of childhood the drop in platelet count may be marked and the hemorrhagic condition very severe. The same is true of aleukemic leukemia. Since the blood picture is not characteristic in this condition, a diagnosis may be difficult unless the bone marrow is examined. In Hodgkins disease thrombopenia is found but hemorrhage is not a common complication. Malignant metastases to the bone marrow may produce a severe thrombocytopenia and occasionally the hemorrhage may be the first sign.

INFECTION

In some instances of infection it appears that the bacterial toxin acts directly on the bone marrow thereby depressing the production of platelets. This is demonstrated in the virulent type of smallpox and diphtheria. The same explanation may hold for the moderate depression of the platelets seen in influenza during the first week of the disease. In the majority of instances however, the development of an allergic-like condition seems the most plausible explanation. Purpura associated with the acute exanthemata, with subacute bacterial endocarditis, and Rocky Mt. spotted fever is frequently seen. Otitis media, tonsillitis, infected sinuses, and acute upper respiratory infections are often followed by a typical picture of purpura. Sometimes a long period of three weeks may intervene between the infection and the appearance of the purpura. Other provocative agents have long latent periods as well. In one case a typical thrombocytopenic purpura developed four days after an insect bite; in another a severe purpura developed five weeks after a small pox vaccination.

ALLERGY

It is well known that certain drugs which have no direct action on the bone marrow can in certain sensitized individuals nevertheless cause a marked fall in the platelet count which is accompanied by a bleeding tendency. The list includes quinine, iodine, belladonna, nevarsphenamine. Curiously individuals who show a marked sensitivity to this drug may show no reaction to mepharsen. Food allergy as a cause of thrombocytopenic purpura has been established only recently.

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Psychotherapy of the Obese Patient

The following remarks are limited to obesity of the exogenous type, mainly as it is encountered in women. The discussion refers to individual treatment as carried out by the practitioner under the usual conditions of a medical visit. Space does not permit the discussion of other important factors, such as family relationships, or the influence of the personal, social, or economic environment.

The only way in which fat or its precursors can enter the body of the obese person is through the mouth. Fat is deposited in the tissues only when the calories of food which are absorbed through the intestinal wall exceed those which are utilized in the production of energy. Obesity of all types is the result of a disturbance in caloric balance. The patient who says—"I didn't eat nothing, doctor, and still I can't reduce"—is invoking magic, and expects a magical cure. Research in metabolism and endocrinology have given little indication as to how the caloric balance is tipped in favor of the accumulation of fat. The question, which is still to be clarified, is why the obese person eats more than she can oxidize. The fundamental questions have not been answered: "What does the disease due to the patient? What does it do for the patient? How come? What to do, and how to do it?"

The only person who can supply the answers to this question is the patient. On suitable inquiry a number of motives for excessive eating can be elicited, in addition to the appetite. This is usually increased, but zest for food may be totally absent. Perhaps the most frequent complaint is a feeling of emptiness, a boundless void, which can never be filled, or which recurs immediately after eating. This feeling is intensified in situations of emotional stress. Thus it is out of proportion to the physiologic needs, and, therefore, is not so much an appetite as a craving.

It is clear then what the disorder does to the obese patient. It functions as a disease, in that it causes suffering, and interferes with the life adjustment. It is clear also that the illness does something for the patient; it constitutes a psychologic gain.—Henry B. Richardson, M.D., New York City. *New York State Journal of Medicine*, Vol. 47, No. 23, December 1, 1947.

Contraindications and Indications for Pentothal Sodium

RALPH SOMMERFIELD, M. D.

IT is not advisable to lay down hard and fast contraindications and indications for the use of pentothal sodium. Several things must be considered. The skill of the administrator, the skill of the surgeon, the type and location of the operation, the availability of adequate equipment and apparatus and the ease with which an airway can be maintained, are all factors which should be evaluated before choosing an anesthetic for any patient. A large number of persons, physicians, dentists, nurses, and technicians are administering pentothal sodium. Because of its seeming simplicity, pentothal is being administered by many with immature anesthetic judgment. What may be an indication or method of choice to the anesthesiologists may be a definite contraindication to the unskilled anesthetist. The casual and infrequent administrator should limit its use to the so-called average case, i.e., one of short duration and in which no special skill is required. Those cases requiring more specialized application should be left to the more experienced anesthesiologist.

Most contraindications are relative, not absolute. Heard¹ makes the following statement with which I am in full accord. "There is, however, one contraindication which transcends all others. It must be the final arbiter in every case in which pentothal is being considered. It is, inability to maintain a clear airway, whether that inability arises from the physical condition of the patient, the site of operation, or failure of the anesthetist to realize that actually, he is not succeeding in keeping the air passage open. In the presence of proper oxygenation—and this proviso is of the utmost importance—few physical conditions are absolute contraindications."

The unavailability of oxygen under pressure should be considered to be a definite contraindication to pentothal. I feel sure that everyone who is doing anesthesia, has been thankful, on more than one occasion, that oxygen under pressure has been available, or has regretted the fact that it was not immediately at hand.

Physical conditions which only a short time ago were considered contraindications to pentothal are no longer regarded as such. Hepatic disease is no longer considered to be a contraindication. The liver has long been thought of as being the site for the destruction of pentothal. Newer experimental data suggest that the liver is not involved in the destruction of this drug.²

Patients in shock were thought to be poor sub-

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jects for pentothal anesthesia. Adams, Lundy, and Seldon³ state: "Pentothal sodium per se is not any more hazardous than any other anesthetic in cases in which patients are in shock. It is, however, dangerous when administered according to ordinary standards and in ordinary doses." The administration of oxygen and the employment of combined anesthesia makes the administration of pentothal to patients in shock much safer.

Operations about the oropharynx and nasopharynx used to be considered definite contraindications. However, the technic of intratracheal anesthesia with pentothal combined with nitrous oxide and oxygen and more recently in combination with curare now provides a method that is less hazardous.

Because of the poor relaxation produced, intravenous pentothal sodium was not intended for intra-abdominal operations. In combination with curare and nitrous oxide and oxygen a very satisfactory procedure employing pentothal for intra-abdominal operations is made available.⁴ Endoscopy, especially bronchoscopy, when performed under pentothal alone was generally frowned upon. Pentothal in combination with curare⁵ offers a much safer method for this procedure.

It has been said that the administration of pentothal to children was contraindicated. It is contraindicated if it is administered in the same dose and according to the same standards as for adults. Age, in my opinion, should not be a contraindication for the use of this drug. Age is no contraindication to the use of other barbiturates or other drugs. Pentothal has on occasion been given to infants, not in the usual concentration of 2.5 per cent but in a concentration of one fourth of one per cent. In the study of geriatrics and anesthesia, Baird⁶ found that pentothal was associated with the lowest incidence of mortality in which it was being used for minor procedures only.

Sensitivity to the drug, although extremely

Presented during a panel discussion before the Section on Anesthesiology at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947.

rare, should be considered a contraindication. This will only be known if the patient relates an untoward reaction following a previous administration of the pentothal. The administration of pentothal is not recommended as an office procedure. Not only will patients occasionally require considerable time for recovery, but from the medicolegal aspect it is unwise to accept the risk involved. Inability to perform successfully a venepuncture is naturally a contraindication to the intravenous administration of pentothal.

Because of the ease of induction pentothal is indicated as an induction anesthetic prior to inhalation anesthesia. The excitement stage is absent and blood pressure elevation does not occur as frequently as when anesthesia is induced by one of the inhalation anesthetic agents. This is most desirable in the hypertensive patient. The patient with a painful facial defect or who is apprehensive and fears having a mask placed over his face greatly appreciates this type of anesthesia. Since there is no explosive hazard associated with the administration of pentothal, the use of the cautery or X-ray is a definite indication for its use.

The indications for the use of pentothal sodium have increased since this agent was first used. Originally, pentothal was intended to be a complete anesthetic. Because of its limitations as such, newer technics were developed. Its field of usefulness has been greatly widened by its use in combination with regional, spinal, inhalational agents, and curare.

Long and Ochsner⁷ in 1942 wrote an exhaustive review of the literature. The indications for pentothal outnumbered by far the contraindications. Many writers reported that the elderly and debilitated tolerated intravenous pentothal sodium especially well and it was the method of choice not only in these poor risk groups but also in diabetes, myocardial degeneration, asthma, chronic bronchitis, pulmonary tuberculosis, and surgical shock.

There is practically no field in the practice of medicine and surgery in which this drug has not been used. Pentothal is an ideal supplement for spinal anesthesia. When used in combination with cyclopropane, nitrous oxide and oxygen and curare, the results are very gratifying.

Other than surgical conditions in which pentothal has been found to be useful and in which its use is indicated is in the treatment of convulsions during anesthesia⁸ or due to tetanus⁹ and toxæmias and in the field of psychiatry as an adjunct to psychotherapy.¹⁰

Pentothal sodium anesthesia has been widely employed since it was first used clinically. It has gained impetus as a result of its use as a wartime anesthetic, and until a superior agent is developed, it will continue to play a major role in anesthesiology.

SUMMARY

The contraindications and indications for the use of intravenous pentothal sodium have been briefly discussed. Inexperienced personnel, inability to maintain a clear airway, and the unavailability of oxygen under pressure should be considered absolute contraindications.

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Nutritional Aspects of Arterial Hypertension

In the pathogenesis of arterial hypertension the circulatory blood volume seems to play a significant role. Increase in the circulatory blood volume is followed by an increase in the blood pressure; decrease of the circulatory blood volume is followed by a decrease in the blood pressure. Other factors also enter into the development of arterial hypertension, but the circulatory blood volume alone is distinguished by being more easily accessible to therapeutic approach.

Aiming at the reduction of the circulatory blood volume the antiretentional diet was employed. This diet is rich in proteins and vitamins, and is restricted to a greater or lesser extent in carbohydrates, fats, table salt, and liquids. For a man of average height and weight, and under ordinary living and working conditions, this diet would consist of from 112 to 135 gm. of proteins, from 150 to 260 gm. of carbohydrates, from 40 to 50 gm. of fat, from 1 to 1½ L. of liquids (including the fluid content of fruits), and the smallest amount of table salt compatible with the enjoyment of the meal.

Administration of the diet was followed by a reduction of the blood pressure in many instances, and the validity of the original observation was confirmed during the years in a great number of cases.—E. Foldes, M.D., N.Y.C., *New York State Jrnl. of Medicine*, Vol. 47, No. 24, December 15, 1947.

Intracapsular Cataract Extraction

E. J. WENAAS, M.D.

ACCORDING to present-day standards, the ideal operation for cataract is the removal of the lens in its capsule, leaving a round pupil. This operation may not always be possible of execution, and should not be attempted in every case. The surgeon should be able to, and be prepared to change his technic to cope with the situation as it may arise. The most frequent complications that arise during the operation are: Loss of vitreous; rupture of the lens capsule, or both; and severe hemorrhage. These complications, except in unusual instances, mean poor selection as to type or time of operation chosen, or faulty operative technic.

An intracapsular cataract extraction requires that the zonule be ruptured at its union with the lens capsule, whether it be done by external pressure alone as advocated by Smith;¹ the use of forceps and external pressure or by forceps alone; vacuum cup extraction by the Barraquer erisophake, or the simpler Dimitry² suction disc; zonular stripping as described by Kirby;³ electro coagulation or loop extraction. Regardless of what method is used, the procedure must be done gently. It depends on delicacy of touch and grasp that is gained through observation and experience, which is not usually acquired until a few capsules have been ruptured. Every technic has its enthusiast, and in his hands the end result may justify his enthusiasm.

CASE ANALYSIS

A careful analysis of your own cases may show some surprisingly good or bad results when compared with published reports and in that way be of real value. With such a comparison in mind, I have taken the intracapsular cataract extractions done or attempted in my private practice during '44, '45, and '46, (excluding congenital, subluxated or luxated, traumatic cataracts, and those cases of discission followed by linear extraction) as a basis for discussion.

OPERATION

The routine operative procedure has been the same for all: Preoperative sedation, instillation of 4 per cent cocaine, homatropine and neosynephrine to get maximum pupillary dilatation, Van Lint lid akinesia, retrobulbar novocaine injection, superior rectus suture, and full external canthotomy when indicated. A two-fifths section is made with a cataract knife and enlarged to one

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half with scissors. The section is made almost corneal with no attempt to get a large conjunctival flap. Three corneoscleral sutures are inserted: First, the wing sutures at 2 and 10 o'clock on the corneal dial; and then the central suture which is used as a traction suture to lift the corneal flap if desired. In some cases I leave a small uncut section at the top and insert the two wing sutures, then complete the section with scissors. This gives better support to the eye and aids in getting exact apposition of the wing sutures. There are many other satisfactory methods of suturing which may be as practical and safe as using these three corneoscleral sutures, but I find no particular difficulty in inserting or removing them. The complications of prolapsed iris or gaping of wounds is minimal, and well-coapted wound edges discourages hemorrhage if the corneoscleral section has not been too deep.

In a fairly high percentage of cases (about 10 per cent) I find that the iris will float in front of the knife after the counter puncture is made, and the anterior chamber empties rapidly. When this occurs, I withdraw the knife and complete the section with scissors. I see no objection to using scissors to complete a section or to make a section after a keratome incision—there is no interference with healing, no increased postoperative reaction or astigmatism. A good section is so important to the outcome of the operation, that the occasional operator who does not have full confidence in his ability with the knife should, by all means, use a keratome and scissors. When using a scissors, too large a cut should not be made to avoid wrinkling of the cornea, and the scissor blade should be used parallel to the plane of the iris, simulating a knife section as closely as possible.

The next step is a complete or peripheral iridectomy done under direct view by lifting the corneal flap with the center suture. The iridectomy is always performed before the cataract

Presented before the Section on Eye, Ear, Nose, and Throat at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947. A motion picture was shown, following the paper, illustrating cataract extractions.

extraction as the vitreous face is directly behind the iris after the extraction and there is danger of vitreous loss if the iridectomy follows the extraction. The retention of a round pupil is desirable, both for optical and cosmetic reasons, although a round pupil extraction should not be attempted if the operative result will be endangered. A pupil which will not dilate to more than four or five millimeters complicates the operation too much and should have a complete iridectomy. I have found that a round pupil, when well dilated, does not make the cataract extraction much more difficult; in fact, I believe it helps to prevent loss of vitreous, and it surely adds support to the vitreous postoperatively when the pupil assumes its normal size. In any case, where there is loss of vitreous a complete iridectomy is an absolute necessity.

ZONULE RESISTANCE

The ease with which the cataract can be removed depends on the resistance of the zonule, no matter what method is used. No rule can be formulated as to which zonule will be resistant, but generally they are found in the patient under the age of fifty. The younger the patient and the more immature the cataract, the more resistant and resilient the zonule will be. The patient

TABLE 1. AGE AND SEX OF PATIENTS

Age	No. of Cases	Sex
30 to 40 yrs.	1	Male 96
40 to 50 yrs.	13	Female 116
50 to 60 yrs.	63	
60 to 70 yrs.	65	
70 to 80 yrs.	62	
80 to 90 yrs.	8	

TABLE 2. TYPE OF CATARACTS

Mature	88
Immature	102
Hypermature	22

in the sixth, seventh, and eighth decades should have zonules of average resistance, but occasionally one will be encountered that is unusually resistant. In my experience about 10 per cent are resistant; 10 per cent are friable; and 80 per cent are average.

THE EXTRACTION

The actual extraction is done by applying the capsule forceps, grasping the capsule well past the center, and taking approximately a four millimeter bite. It is important to use a capsule forceps whose edge is not too sharp, nor should you press too hard in applying the forceps, as the capsule is easily crushed or cut in this manner. The first traction is directly upward and anterior, and with a blunt muscle hook, counter pressure is made as a series of gentle but definite indentations just inside the corneal margin, opposite

the forceps and at right angles to the zonular fibers. Next, rotate the forceps and re-apply pressure to the opposite side; and repeat the maneuver with the traction being constant and the external pressure being of a stripping nature. When the zonule ruptures, the lens is seen to rise into the anterior chamber and the forceps merely

TABLE 3. TYPE OF OPERATION

Preliminary Iridectomy	2
Extraction combined with iridectomy	105
Extraction with peripheral iridectomy	105

TABLE 4. COMPLICATIONS DURING EXTRACTION

Ruptured Capsules	10—4.7%
Vitreous Loss	15—7.05%

TABLE 5. VISUAL ACUITY RESULTS

Vision	No. of cases	Percentage
20/20 or better	132	62.4
20/25	20	9.4
20/30	21	9.9
20/40	13	6.1
20/50	10	4.5
20/100	6	2.8
20/200 or less	10	4.7
Thus 88% have 20/40 vision or better.		

act as a guide to tumble the lens out, and the major force is external pressure applied in an upward direction. I have often found myself pushing against the free tumbling of the lens by applying pressure too far forward, and it is a point to remember. The forceps is not released as the lens becomes dislocated, and the lens is followed by external pressure over the surface of the cornea.

In a few cases, the maneuver of traction and application of pressure will not rupture the zonule, and too violent manipulation can only result in rupture of the capsule or vitreous loss, or both. The limits of safety for traction and pressure are learned only by experience, and the most important point is to know when to stop and attempt another method. On those cases, I find that zonular stripping, as described so adequately by Kirby,³ is safe and a good procedure. So far, in those cases of zonular stripping, I have always done an iridectomy although Kirby does it at times with a round pupil.

The suction method of cataract extraction is a method that has been attempted by many men, and the equipment is varied, with each apparatus modified. Hulen, Barraquer, Green, Fisher, Dimitry, and many others have written on the subject. I am personally familiar only with the Dimitry suction apparatus, although I have seen others used. We first purchased a Dimitry suction disc in 1940, but my initial attempts were so unsuccessful that I discontinued the use of it; mainly because it felt clumsy and I could not

use it delicately; also because I tried to slide the cataract from the eye and invariably lost the suction. About a year ago, I began using it again, only in a different way. I now hold the instrument like a pen in the right hand; depress the plunger with the left hand; introduce the disc into the anterior chamber; and apply the

TABLE 6. ANALYSIS CASES OF VITREOUS LOST		
Vision	No. of cases	Astigmatism Avg.
20/20	6	2.25d
20/30	2	1.75d
20/40	2	2d
20/50	2	2d (1 Diabetic retinitis)
20/100	2	2d (1 Central scotoma)
20/200—Later H.M.—Uveitis—Plastic iritis—diabetic.		

TABLE 7. ANALYSIS (10 CASES) CAPSULE RUPTURED DURING EXTRACTION	
No. of Cases	Vision
1 Ruptured capsule and Vitreous Loss	H.M. diabetic
1 Whole lens delivered	20/20
1 Discission	20/20
1 Secondary Glaucoma miotic controlled	20/30
5 Uncomplicated	20/20
1 Plastic Uveitis	H.M.
1 Uveitis—Secondary Glaucoma—Enucleation.	

suction disc below the center of the cataract much as you do a capsule forceps. External pressure is applied with a muscle hook and the traction is made with an upward tumbling motion, always keeping the suction disc in such a way that the force is applied at right angles to the lens surface. This is to keep the suction disc from sliding on the smooth surface of the lens capsule and losing the negative pressure. The suction is kept at right angles to the capsule throughout the extraction and the lens is tumbled, actually being inverted when removed through the corneoscleral incision.

SUCTION

Most writers do not favor the suction method of cataract extraction except in very selected cases, and mention the complications of its use as rupturing the capsule and the danger of sucking the vitreous body into the instrument. These objections may be valid with the vacuum apparatus with unlimited capacity; or where it cannot be disconnected quickly; but in the Dimitry syringe the capacity is only 2 cc. and the danger is minimal. In a few cases, I have lost the suction suddenly in the anterior chamber, both before and after the zonular rupture, and have re-applied the suction disc without any complications or difficulty.

The external pressure necessary is not great—ordinarily it is said that there is 10 per cent traction and 90 per cent external pressure necessary to remove a cataract successfully with

the capsule forceps, but I believe I reserve those figures in using the Dimitry suction disc, although I have no way of actually measuring the relationship between pressure and traction. I have removed cataracts with the suction disc without applying external pressure, just to prove to myself that this is true, although I believe a little external pressure helps in the maneuver. Dimitry² in his discussion of his suction disc stated: "I would have it noted that neither the sucker nor a forceps is used to pull the lens from the eye. The lens is, in fact, pushed from the eye, the forceps or grasper being used merely as a guide."

I do not assume that this is a new technic because others have used the suction apparatus to tumble a lens in an extraction (Barraquer⁴) but the usual method is to lift and slide the lens from the eye. Jackson and Howard⁵ reported 50 cases of cataract extraction with the Dimitry method with ruptured capsules in five and loss of vitreous in four cases; Quinn⁶ 30 cases with two ruptured capsules and with loss of vitreous; Griffey⁷ 19 cases with ruptured capsules in two cases and loss of vitreous in two cases. Geme-roy⁸ reported 56 eyes operated on by a slightly modified Dimitry suction disc with loss of vitreous in seven cases and ruptured capsules in six

TABLE 8. AMOUNT OF ASTIGMATISM	
1d or less	36 %
1d to 2d	41 %
2d to 3d	20.6 %
3d to 4d	1 %
4d to 5d	1.4 %
77% had less than 2d.	

TABLE 9. RECORD (16 cases) VISION 20/100 OR LESS	
2—Central chorio retinitis	
6—Diabetic retinopathy	
3—Plastic uveitis—diabetic	
2—Congenital nystagmus	
1—Opaque cornea	
1—Uveitis, secondary glaucoma, enucleation	

TABLE 10. POSTOPERATIVE COMPLICATIONS	
2—Prolapsed Iris—Same patient—Pillars excised with final vision 20/20 o.u.	
7—Hyphemia—None severe.	
3—Secondary Glaucoma—2 temporarily controlled by miotics—one required surgery.	
2—Detached Retina—One 3 mos. and one 4 mos. postoperatively.	
4—Severe Uveitis.	
1—Opaque Cornea.	

cases. These operators slid the lens from the eye rather than tumbling, and in these 155 cases in no instance was the vitreous sucked into the syringe.

The tables for analysis of 212 cataract extractions include 38 in which the Dimitry suction disc was used and 174 in which capsule forceps were used. The over-all results in these cases compare favorably with reports of other sur-

geons; Berens and Bogart,⁹ Davis,¹⁰ Kirby,¹¹ Knapp,¹² and others.

Since this series was completed I have used the Dimitry suction disc on 36 more cases making a total of 74 consecutive extractions and my results with this have been better. So far there has been no ruptured capsules or loss of vitreous and the end result has been better in that the postoperative reaction has been less. In this series of 74 cases with the Dimitry suction disc, there have been all types of cataracts, except subluxated or luxated lens, and the lack of complications in my hands has been so gratifying that I will continue to use the Dimitry suction disc. With the Thomas¹³ improvement consisting of a 6-inch length of firm rubber tubing connecting the syringe to a handle, the ease of handling the instrument is improved.

I do not advocate changing your operative technic if you are happy with your results but I do believe the suction method of cataract extraction has its place and is worthy of more serious consideration. The suction disc can be used in every case a forceps can be used, plus those cases of tense capsule where the capsule forceps cannot be applied. The complication of ruptured capsules and vitreous loss are less than with forceps and late complications are not increased.

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Preventive Medicine

Humanity has always shunned responsibility. Even today, though there is widespread intellectual acceptance of the concept that much disease is preventable, the emotional attitude is not much altered and illness is considered an intrusion, a misfortune due to factors beyond control of the individual. As a whole we have not yet awakened to the idea that the health of men and women is their own responsibility.—Edward J. Stieglitz, M.D., A Future for Preventive Medicine, The Commonwealth Fund, 1945.

Tuberculosis Abstracts

When a physician encounters an infant or child with a positive tuberculin test, he has six clear-cut responsibilities: he must classify or describe the lesion, judge activity, determine communicability, seek the source of infection, make recommendations for therapy based on specific objective data, and, last, follow each patient carefully at frequent intervals at least until all evidences of activity have subsided or until resolution of the initial lesion is complete.—R. V. Platou, *Am. Rev. of Tbc.*, April, 1947.

* * *

The institution of case-finding routine radiography by hospitals will bring general hospitals face to face with the necessity of providing facilities for temporary handling of some of the discovered cases.

Routine chest X-raying should not be deferred simply because of the fact that cases of tuberculosis will be discovered. These patients are in hospitals for other reasons in the first place. Failure to discover tuberculosis results in these undiagnosed cases of tuberculosis exposing other patients and employees to tuberculosis. Until new construction permits adequate care for tuberculosis itself, hospitals should be able, with the aid of the manual, "The Management of Tuberculosis in Hospitals", to accept with safety tuberculosis patients for non-tuberculosis treatment.—The Opportunity, Robin C. Buerki, M.D., Hospitals, August, 1946.

* * *

The infected infant may be able to overcome tuberculous infection if the adult contact can be promptly removed. If, however, the contact remains and the baby is subjected to a constant opportunity for more infection, there is much greater likelihood of a serious, or even fatal outcome.—E. L. Kendig, M. D., and J. B. Hardy, M. D., *South. Med. Jour.*, April, 1946.

* * *

Although roentgenograms play an all-important role in objectively discovering and delineating tuberculosis lesions, they will never be accurate enough to supplant sound medical judgment.—R. V. Platou, M. D., *Am. Rev. Tbc.*, April, 1947.

* * *

The tuberculosis control program appears to have been quite successful among women so far as reduction of the death rate is concerned, while in the case of men the principal evidence of success has to do with the advancing age at death.—Mary Dempsey, *Am. Rev. Tbc.*, Aug., 1947.

An Experiment With Uterine Cervical Smears In The Diagnosis of Genital Malignancies

GEORGE M. WILCOXON, M.D., and FREDERICK H. FALLS, M.D.

THE diagnosis of female genital tract malignancies is important to a great many doctors in the practice of medicine. Of all the primary cancers occurring in women the female genital tract gives rise to 24.6 per cent of these malignancies. Only the digestive system leads the reproductive system in starting malignancies in women. Primary breast cancers account for 18.4 per cent of the malignancies.⁷ Every physician who treats women patients must give serious consideration to these facts.

In recent years several publications have appeared in which the vaginal smear has been used for the diagnosis of female genital tract malignancies. Papanicolaou,⁶ Meigs,⁴ Jones,³ and Ayre¹ have shown that uterine malignancies can be diagnosed by the vaginal smear technique. Ruth Graham² has demonstrated that along with the diagnosis of uterine cancer the vaginal smear can be very valuable in following the treatment of uterine malignancies by radiation therapy.

In this study the technique of vaginal smears has been applied to the uterine cervix. A glass pipette was attached to a rubber suction bulb. Care was taken that the glass pipette was clean and dry as any water in the pipette changes the cellular detail. After the insertion of a speculum into the vagina the cervical os was exposed. The rubber bulb was compressed and the tip of the glass pipette was inserted into the cervical canal for approximately one inch. Compression on the rubber bulb was released and the glass tip gradually withdrawn so as to collect the cervical mucous plug in the pipette. If necessary this was repeated until some of the cervical secretions could be seen within the glass pipette. The material obtained in the pipette was blown on a previously marked glass slide. The material was smeared across the slide with the tip of the pipette and the slide immediately dropped into a bottle filled with fixing solution (one half ether and one half 95 per cent alcohol). Since drying destroys the cellular detail it is essential that the slide be placed immediately in the fixative. Fixation for five minutes is sufficient, but slides may be left in the fixing solution without deterioration for as long as two weeks.

PREPARATION OF SMEARS

The slides are stained after the method developed by Papanicolaou. The slides are taken

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from the fixing solution and are placed in a dipping tray. The tray is then dipped ten times in two jars of 80 per cent alcohol. This is followed by dipping in 70 and 50 per cent alcohol solutions. Dipping is continued in a jar of distilled water after which the slides are stained for one minute in Harris hematoxylin. The slides are then washed in two jars of distilled water before being stained in Papanicolaou's lithium carbonate solution which is three drops per one hundred cubic centimeters of tap water. The slides are stained for one minute. The slide tray is then placed in running water for five minutes. After washing in distilled water the slides are dipped in 50, 70, 80, and 95 per cent alcohol solutions in the order named. One minute staining is then accomplished in lithium carbonate solution which is ten drops per two hundred cubic centimeters of 95 per cent alcohol. This is followed by two washes in 95 per cent alcohol before the slides are placed in OG solution for one minute. Two more dippings in 95 per cent alcohol are followed by two minutes staining in Papanicolaou's EA 50. This is followed with three washings in 95 per cent alcohol, absolute alcohol, absolute xylol, and two xylol dippings. The slides are then mounted in the usual manner.

CASES INVESTIGATED

Cervical smears were prepared on the new cases presenting themselves to the cancer clinic at Research and Educational Hospitals of the University of Illinois and on the cases admitted to the Gynecological Service of Research and Educational Hospitals.

With the methods described, 236 cases were studied and followed in the hospital and clinic.

From the Department of Obstetrics and Gynecology, University of Illinois School of Medicine, Chicago, Illinois. Submitted May 15, 1947.

TABLE I.

Proved Negative Cases	
Fibroids	35
Chronic cervicitis	26
Polyp	20
Normal endometrium	20
Adenomyosis	9
Chronic endometritis	9
Secretory endometrium	8
No evidence of malignancy	5
Endometrial hyperplasia	4
Squamous cell mataplasia of cervix	3
Proliferative endometrium	3
Tuberculous peritonitis	2
Tuberculous endometritis	2
Polypoid endometrium	1
Endometriosis, ovarian	1
Atrophic endometrium	1

Of the 236 patients 198 showed no evidence of cancer. Of the entire series 74.7 per cent had proved pathological diagnosis. The proved negative diagnoses are listed in Table I. The remainder of these patients did not present enough evidence for malignant disease to require operative procedures. In this series of 198 negative cases 18 mistaken positive diagnoses were made. These are all regarded as mistakes since no positive pathological evidence of malignancy was demonstrated. This represents an error of 9 per cent in negative called positive cases. Of the total number of cases followed, these 18 mistakes represent an error of 7.6 per cent.

In this series of 236 cases, 38 were shown to have cancer. The positive cases are listed in Table II. Of the 38 cancer cases two were called negative and are regarded as mistakes. One of the mistakes was a case of epidermoid carcinoma of the cervix which was called negative on the first reading. On a subsequent reading of the slide, malignant cells were found. The second case listed as a mistake was a leiomyosarcoma of the uterus from a degenerating fibroid. The uterine mucosa was normal and this malignancy probably never exfoliated any malignant cells into the uterine canal. These two mistakes in the 38 malignant cases represent an error of 5.2 per cent. In the series of 236 cases the two mistakes of positive called negative represent an error of 0.84 per cent.

In this paper it is not necessary to give the method of diagnosis of individual cells. This has been included in several articles and in Papanicolaou and Traut's monograph. However, as Meigs⁵ states in his latest article, a few characteristics of the cells are very important. The nucleus of the cell is the main diagnostic criterion. The cancer cell has a large abnormal nucleus, and in groups a variation in size and shape is obvious. The large nuclei of cells from cervical cancer are radically different from those of the normal cells of the cervical epithelium. It is important to note scarcity of cytoplasm compared to the amount seen in the normal cell. In the cancer cells the large

TABLE II.

Positive Cases	
Epidermoid carcinoma of the cervix	18
Adenocarcinoma of the uterus	4
Clinically positive	3
Squamous carcinoma of the cervix	3
Leiomyosarcoma of the uterus	2
Papillary type, origin unknown	2
Epidermoid type, origin unknown	1
Adenoacanthoma of the uterus	1
Metastasis, cystadenocarcinoma of ovary	1
Carcinoma of the vagina	1
Carcinoma of Skene's gland	1
Carcinoma of the vulva	1

nucleus takes up most of the cytoplasmic space and the ratio of nucleus to cytoplasm is different from that in the normal cell. In cancer of the endometrium the same criteria are true, but there is less variation in size and shape of the nucleus and less evidence of a differing in size from the normal nucleus. Yet the difference is real and can be observed. The presence of histiocytes and many leucocytes is a suspicious observation but it is not diagnostic. The presence of blood is important, but its absence does not indicate a negative diagnosis. The most important observation is the abnormal nucleus and its size in relation to that of the rest of the cell.

The positive cases include 21 cases of carcinoma of the cervix. Epidermoid carcinomas accounted for 18 of the cervical malignancies. The remaining three cases were squamous cell carcinomas of the cervix. From the fundus, seven cases of malignancy were demonstrated. Of these seven cases, four were adenocarcinomas, one adenoacanthoma, and two leiomyosarcomas.

PERIODS AND RESULTS

For reading of the cervical smears it was decided to divide the total time into three separate periods. In Period I the smears were to be read strictly according to the method of Papanicolaou, this method having been learned after personal study with Papanicolaou.

Period II was the experimental part of the study. Smears which showed unknown cells or cells not described in the literature were called positive. In these positive cases in which there was already an existing pathology, a surgical procedure was carried out. For example, if a case had a cell on the smear which did not fall within Papanicolaou's classification for a cancer cell and the cell was not of the known normal cells and the patient had a small fibroid, a total hysterectomy was done.

Period III was the part of the study in which the criteria for Period I and the information gained from the study of Period II were correlated into the making of a diagnosis in all smears examined in this period.

In Period I there were 21 proven malignant cases examined. One case called negative from

TABLE A

Periods	Total Cases	Positive Cases	Positive Cases Called Negative	Negative Cases	Negative Cases Called Positive
I	54	21	1	33	3
II	89	11	1	78	15
III	93	6	0	87	0

the smear was proved to be malignant. This smear was re-read and malignant cells were found on the smear. This mistake was due to the human error in reading smears, an error which must be considered in all smears since cancer cells may be present on the smear and missed by the reader. This mistake was made when the smears were being read without the use of a mechanical stage. It is now thought that every area of a smear can not be accurately investigated without the systematic use of a mechanical stage. This experience developed into a valuable point in reading smears.

Negative cases in Period I totalled 33. Of these 33 negative cases, three were read as positive and no proven pathology demonstrated. Two of the three cases called positive were chronic cervicitis cases. One case had a tissue biopsy and the other a Sturmdorf operation. The other case had a subtotal hysterectomy with a cauterization of the cervix at the time of the operation. In Period I a total of 54 cases were examined by the cervical smear and four mistakes were made.

In Period II, the experimental part of the study, there were 11 proved pathological malignancies. One of these proved malignant cases was considered a negative fibroid clinically. The smear was read as positive for malignant cells. A subtotal hysterectomy with cauterization of the cervix was done. The pathology revealed a leiomyosarcoma of the uterus. Thus the positive smear diagnosis was proved pathologically.

During this experimental phase of the study all unknown cells were studied and a decision was made whether it was thought they were malignant or not. None of the unknown cells were marked suspicious. They were called positive or negative for malignancies.

In this experimental stage 15 cases were called positive by the smear and no proved pathological malignancy was demonstrated. There were six total hysterectomies, three subtotal hysterectomies with cauterization of the cervix, three vaginal hysterectomies, two dilatation and curettages, one endometrial biopsy, and one Sturmdorf operation as listed in Table B. The pathological diagnoses included, adenomyosis three, fibroids three, chronic cervicitis with decidual changes

PERIOD II.

TABLE B OPERATIONS

Hysterectomy, Total	6
Hysterectomy, subtotal with cervical cauterization	3
Hysterectomy, vaginal	2
Dilatation and Curettage	2
Endometrial Biopsy	1
Sturmdorf	1

PERIOD II.

TABLE C. RESULTS BY PATHOLOGY

Adenomyosis	3
Fibroids	3
Chronic cervicitis with decidual changes	2
Chronic cervicitis	1
Multiple interstitial myomata	1
Epithelial inclusion in cervical wall	1
Secretory endometrium showing focal areas of hemorrhage and infiltration	1
Atrophic endometrium	1
Normal endometrium	1
Leiomyosarcoma	1

two, and one case each of the following: chronic cervicitis, multiple interstitial myomata, epithelial inclusion in cervical wall, secretory endometrium showing focal areas of hemorrhage and infiltration, atrophic endometrium, normal endometrium, and leiomyosarcoma. They are listed in Table C. A total of 78 negative smears were prepared during this part of the study.

Using the experience gained in Period II and the criteria used in Period I, no mistakes were made in Period III. A total of 93 cases were examined in this period and no mistakes were made either on the positive or the negative reading of the cervical smears. Table A shows a summary of the cases divided into the periods of examination.

SUMMARY

The cervical smear is an accurate method to be used in the diagnosis of female genital tract malignancies. A mechanical stage should be used systematically in examining all cervical smears. Criteria by Papanicolaou and Meigs for the examination of vaginal smears can be used for the reading of smears prepared from the cervical os. Results of a study of unknown cells in cervical smears correlated with surgical procedures and proved pathology are presented.

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Dissecting Aneurysm of the Middle Cerebral Artery

THOMAS L. RAMSEY, M. D., and VINCENT T. MOSQUERA, M. D.

IN 1930, Forbus¹ presented a case in which there were four small aneurysms at the branching of the cerebral arteries. He stated that an absence of the media is found at the bifurcation of the cerebral and other arteries. The fact that no other vascular changes were found made Forbus conclude that such

parently dependent upon degenerative changes in the medial coat.

2. The underlying cause of the medial change is probably obliteration of a large number of vasa vasorum from arteriosclerosis or a low grade inflammatory process.

3. The aneurysm begins by a rupture of



Fig. 1. One fourth natural size. Aneurysm of right middle cerebral artery. Probe seen entering artery and into aneurysmal sac. 'X' with line shows where rupture occurred with subarachnoid hemorrhage.

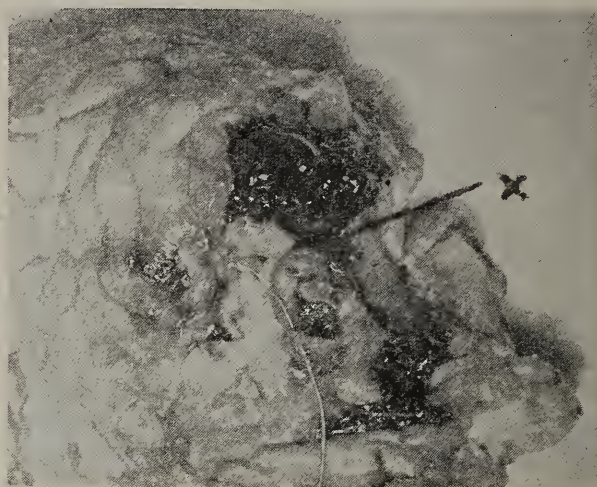


Fig. 2. One fourth natural size. Aneurysm as seen when opened. Probe passes through opening of the artery just proximal to the distended portion. Clot seen in sac also large dark clot issuing from point of rupture.

aneurysms were congenital and he believed the etiology was due to the medial defect.

In 1933, C. R. Tuthill² described six cases of aneurysms of the cerebral arteries and found various stages of arteriosclerotic change in the walls of the aneurysms and stated that no distinction could be made between arteriosclerotic aneurysms and congenital ones. To him the so-called medial defect at the bifurcation of the vessels is explainable as an embedding artefact because of the irregularity of the vascular bed in these areas and the twisting of the vessels from elasticity.

The histo-pathologic changes in dissecting aneurysms are due to the so-called idiopathic cystic medial necrosis and represent a penetration of blood along the media of an artery with or without communication with the lumen. The site of origin of these dissecting aneurysms is practically limited to the aorta with secondary involvement of its branches. Loeschke however found instances reported of primary dissecting aneurysms involving the pulmonary, lineal, thyroid, and the cerebral arteries (cited by Tyson³). In his article Tyson concluded that:

1. Development of dissecting aneurysm is ap-

parently dependent upon degenerative changes in the medial coat.

4. A tear in the intima is not a necessary factor in the formation of a dissecting aneurysm.

5. When intimal tears do occur they are probably secondary to the development of the aneurysm.

Moore⁴ states that in most instances the outer wall breaks at the same or at some other point.

In 1943, Sahs and Keil⁵ reviewed the clinical features in 64 cases in which a diagnosis was made of subarachnoid hemorrhage of non-traumatic origin. They discussed the pathologic findings in twelve patients who died as the result of rupture of aneurysms located in and around the circle of Willis. They stated that the etiologic factors to be considered for such aneurysms are: Congenital weakness of vessels, arteriosclerosis, inflammation, and trauma. The microscopic findings in the aneurysms in the twelve autopsies are classified as to etiology as follows: Nine, congenital; one, inflammatory; one, inflammatory (questionable); one, arteriosclerosis. All of these cases occurred at points of bifurcation of the vessels.

They summarized histo-pathologic changes as

From the Department of Pathology, St. Vincent's Hospital, Toledo, Ohio. Submitted August 22, 1947, as one in the series of "Case Records Presenting Clinical Problems".

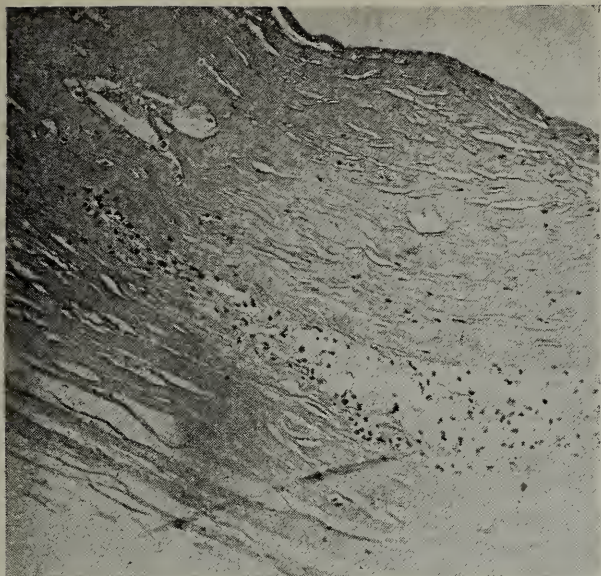


Fig. 3. x100. Aneurysmal area middle cerebral artery. Marked thickening of medial coat, splitting of elastic fibers and cystic medial necrosis. This followed by hemorrhage into media and the formation of the aneurysm.

follows: 1. Thinning of the aneurysmal wall. 2. Hyalinization and fibrosis of the wall. 3. Proliferation of the intima. 4. Attenuation and straightening of the elastic membrane. 5. Thinning or absence of the media. 6. Cellular infiltration.

In the conclusions drawn by the authors in the 12 cases in which a postmortem examination was performed, they enumerated as common etiologic factors the following sources: congenital weakness of the vessel walls, arteriosclerosis, inflammation, and trauma. They also stated that long standing structural weakness of the vessel wall plus the mechanical factors induced at the bifurcations offer the more logical explanation in the majority of these aneurysms.

1. In most of the reported cases of aneurysms of the cerebral vessels the existence of a congenital weakness of the wall or a medial defect of the vessel has been emphasized as described by Forbus. This was not the finding in Tyson's cases and was not present in the case we are reporting. In our case there was no medial defect or evidence of a congenital weakness of the arterial wall but arteriosclerosis, medial necrosis and inflammatory leukocytic infiltration were present.

CASE REPORT

Forty-seven years old, white male, admitted to hospital on August 11, 1946. Present illness: Patient was in apparently good health until 11 p. m. of the day of admission. He had worked all day and worked in the evening in his garden. After retiring he had a coughing spell. He arose and went to the bathroom, acted like he wanted to vomit and then became unconscious. Sent to the hospital in a comatose condition. History: For about two weeks the patient had had occipital headache. Nothing in his past history revealed anything contributory to the present illness. Physical Examination: Well-developed, fairly well-nourished white male, comatose and could



Fig. 4. x100. Advanced atherosclerosis with deposition of calcium in wall of middle cerebral artery. Lymphocytic cellular infiltrate in tissues of adventitia, probably a defense mechanism resulting from irritation of the tissues by the developing sclerotic aneurysmal wall.

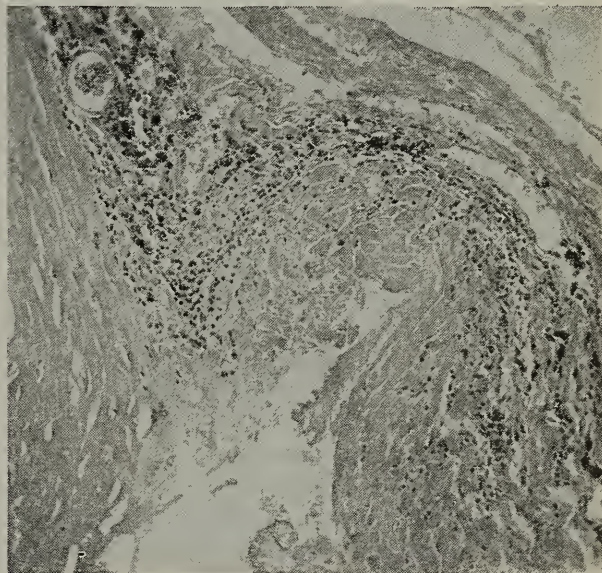


Fig. 5. x100. Aneurysmal wall of ruptured area. Marked lymphocytic infiltrate in adventitial tissue. This probably preceded the rupture in this area. The rupture occurring from the dissecting channel in the medial coat.

not be aroused; pulse: 78; respiration 12; blood pressure 125/70; eyes: circular nystagmus, pupils pin point, possibly due to morphine.

Fine crepitant rales in both bases of the lungs. Heart sounds of good quality. No murmurs, rate normal. Neurological review: Movement of arm and leg present on the right side, and absent on the left side. Droop of left side of the mouth. Left extremities flaccid and the reflexes were hyperactive.

Laboratory findings: RBC. 5,000,000. Hb. 97 per cent 14.5 gms. WBC. 21,200. Polys. 80 per cent. Urinalysis: Sugar 3 plus. Microscopic: Occasional WBC and RBC. Clinical course: On August 13, 1946, the patient had several convulsions. On August 14, 1946 physician called in

consultation gave his opinion, "ruptured congenital aneurysm, probably in the region of the circle of Willis". Patient's temperature was around 100. Kept in an oxygen tent and given sustaining medication. He expired August 14, 1946, three days after admission.

AUTOPSY

Only the most important pathological findings are herein noted. Well-developed, fairly well-nourished white male, measuring 142 cm. in length. The lungs: Chronic emphysema, congestion and edema, with occasional small areas of hemorrhage. The heart: Slight hypertrophy of the left ventricular wall and a slight fatty infiltration of the muscle of the right ventricle. The coronary arteries: Marked arteriosclerosis with constriction of the lumens but no occlusion. Aorta: Advanced degree of atherosclerosis. The spleen: Showed occasional hemorrhagic areas having the gross appearance of infarcts. Liver: A slight degree of acute congestion. The pancreas, kidneys and urinary bladder: Some congestion, particularly the bladder. The gastrointestinal tract: No abnormalities.

Brain: After removal of the calvarium a massive subarachnoid hemorrhage was found with large clots of blood localized over the right frontal and temporal lobes. Dissection of the arteries at the base of the brain showed an aneurysmal dilatation of the right middle cerebral artery measuring 16 x 25 mm. and located 30 mm. from the circle of Willis. This had dissected the wall of this vessel and then ruptured at the point of the second bifurcation in an area near the insula. After a fixation of the brain, the aneurysm was opened and a large clot was found which grossly appeared to be a hematoma in the wall of the aneurysm. This had split the medial coat and broken through the outer coat of the vessel about 10 mm. from the area of the split in the medial coat. (Figure 5.)

Sections from the middle cerebral artery in the area of the aneurysm and at the point of the rupture showed marked arteriosclerosis and cystic medial degeneration. There was a moderate degree of leukocytic infiltration present about the point of rupture. The medial coat contained large numbers of red cells and there was splitting of the elastic fibers; areas of calcification were seen in the media.

SUMMARY

From the autopsy and the microscopic findings we conclude that this was a dissecting aneurysm of the right middle cerebral artery which had ruptured producing massive subarachnoid hemorrhage.

We have discussed the findings usually seen in dissecting aneurysms, and the pathology usually found in cases of aneurysms of the cerebral arteries. The findings in our case seem rather unusual as we have not found any other authentic case report of dissecting type aneurysm of cerebral arteries in the literature that has been available to us.

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Banti's Syndrome Due to Portal Stenosis

When a diagnosis of Banti's syndrome can be made from combined clinical and pathological evidence, the problem of etiology is encountered.

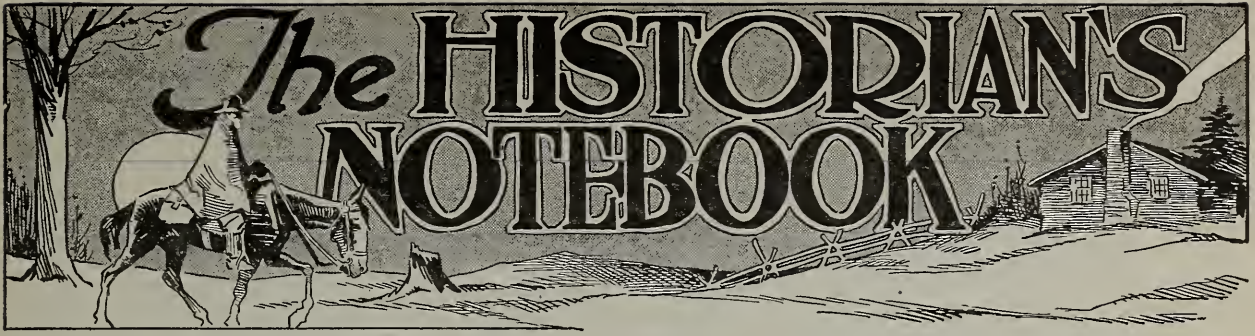
There are two views: One, that Banti's disease as an entity exists in the absence of portal obstruction and the other, that Banti's syndrome is an aftermath of portal hypertension. Followers of the latter idea prefer to label the condition "Congestive Splenomegaly".

The most impressive arguments advanced by those in favor of Banti's disease per se are based on experimental studies. Complete, partial, intermittent, and progressive closure of the portal vein have failed to produce either the microscopic picture or the degree of splenomegaly seen in humans in Banti's disease.

In experimental liver damage, a spleen which is dissociated from the portal system and transplanted into the subcutaneous tissues undergoes hyperplasia. The conclusion drawn from these experiments is that splenomegaly in Banti's disease is due to some "hepatotoxic" agent plus portal hypertension. Injection of silica particles into the portal vein has resulted in total cirrhosis with marked splenomegaly. Some doubt has been cast on the validity of this procedure because of the presence of a few silica particles in the spleen. Unpublished work reporting satisfactory production of chronic portal obstruction with splenomegaly by using cellophane bands around the portal vein has been quoted. Improvement of patients following splenectomy has been interpreted as being due to the removal of toxins, but it seems more likely that the 30 per cent reduction in portal flow caused by removal of the splenic circulation is the real basis for the remissions. Improvement of our patient after the exploratory operation is thought to be due to the development of the omental-hepatic adhesions in which large vessels developed. This might also explain the atrophic liver with absence of cirrhosis.

Those who favor the obstructive factor as the etiology believe the changes occurring are due to portal hypertension. Seventy per cent of cases of Banti's syndrome have demonstrable portal obstruction and many of the remainder are not sufficiently investigated to rule out a portal block. Measurements of the splenic vein pressure in cases of Banti's syndrome at surgery show a significant increase as compared to control cases. No such measurements were made in our case.

Portal cirrhosis of the liver account for 50 per cent of the cases of the congestive splenomegaly. When portal hypertension exists, Banti's syndrome is nearly always present. Extrahepatic portal blocks also are associated with Banti's syndrome.—D. S. Shillan, M.D., Los Angeles. California Medicine, Vol. 67, No. 6, Dec., 1947.



George Crile

We, of the Ohio Committee on Medical Archives and History, decided at our last annual meeting that we would devote the next several years to an exploration of the period 1890 to 1945. Not only because it is the most fertile period in the history of medicine, but because it is possible to catch and keep for posterity more of the many facts before they are lost than we could do if we continued to center on the 1835 Civil War era. George Crile was never a member of this group but it is doubtful if any member of the group with all of its 300 articles and books, will ever make a richer contribution to this study than he has done in his own biography. (*George Crile, Autobiography, edited with side-lights by Grace Crile. \$10.00. Two Volumes. J. B. Lippincott Company, Philadelphia.*)

Doctor Crile's adult life nicely covered this exact epoch. In this period, science made its great advances. Biology gave us histology, pathology, bacteriology, immunology. Chemistry gave us organic chemistry, physiological chemistry, clinical laboratory diagnosis, endocrinology. Physics gave us the X-ray, radium, and the cyclotron. Materia medica gave us the active principles of our old days, sera, chemotherapy, hormones, and blood banks. Truly these last days of the machine age were the golden days of medicine. To George Crile it was given to be an active part of all of this and to adopt all these things to his own needs.

"Because George Crile's life unfolded dramatically and he was dominated by purpose and vision and had unusual associations", his good and dutiful wife formed the habit of keeping everything he wrote. Doctor Crile himself fortunately had the habit of getting things "out of his system" by writing out his thoughts, expressions, dreams, and plans, as well as his philosophical musings. Mrs. Crile had then at her disposal—thirty-four volumes of manuscript, each of 500 pages or more; fifty files of personal memorabilia averaging 350 pages each; thirty-eight volumes of war diaries; and eleven volumes of reprints. During the years she kept these files inviolable. Nothing was ever removed from them

and, as they grew chronologically, they carried the story of George Crile and the medicine of his times.

One is saddened as he reads of Doctor Crile's family, his youth, his education, his early career as a teacher in the medical school, for it is forced upon one that Crile and the world was lucky in that he was born in 1861. Boys like him, and many other leaders of medicine in his day, could never even get to apply to the entrance board of the modern medical school. We are growing up. As a Nation, we are growing old before our time, losing our flexibility. As always happens under such circumstances, we separate into classes based upon our family background. A poor boy can still get to be President of the United States by the greatest of good fortune. But to become a modern surgeon, one has to be the son of a man who can advance something like \$15,000 for one's education. Thus does Medical Education contribute to the downfall of our Republic!

No finer example than the life of George Crile could be brought forward to support Ralph Borsodi's thesis that biologically a normal family consists of three generations. The force of this should never be forgotten in attempting to understand the career of this great man. He came from strong stock to live intimately with the parents of his wife, their children, and his. To be a part of a normal family life is not to be given many of us anymore. Our cities are crowded. There is no place for the old folks. Our children do not have the advantages of going to Grandpa's for like as not Grandfather is in an old folks' home. George Crile had the opportunity of living with his grandfather who as an old man could impress upon that plastic mind the facts of life as seen through the eyes of experience.

Borsodi has spent his life trying to determine what is biologically normal for the human race. As a result of this search, he has confirmed the principles of monogamy. He insists that no man or woman can live a normal life except with a mate. These volumes show conclusively that the

best thing about the life of George Crile was his marriage. Throughout the biography, it is apparent that this man always had at his side a wife who understood him and gave of herself to make her man's dreams come true. Thus, with the proper family upbringing and living in a normal three-generation family, especially with a mother who was able to show her children that work could be fun, George Crile was able to teach school at the age of fifteen and go to work his way through Ohio Northern University (this is before the Association of Colleges had regimented the other fellow's school) and to acquire the education of a cultured gentleman.

By careful selection, Mrs. Crile has given us the full story of the development of modern surgery from the antiseptic days to asepsis, to kitchen-table surgery, of the days of special trains and horses and buggies. All in terms that bring back vividly these same days in my youth on the Western Reserve. Then came transfusion as explained to the members of the old Starling-Loving Society of S.O.M.C. by Doctor Crile who was not too busy in those days to come down to Columbus to talk to a student's medical society.

Doctor Crile's persistent and fruitful study of shock and exhaustion, with which he came into contact in World War I, established his name among great medical teachers. His appearance marked the end of the Anatomical Age of surgery and the beginning of that of Experimental Surgery. Crile was one of those who always serves as an advanced guard. He, however, always kept his line of communication back to the main body of facts. This has always made him a target for those who insist that nothing should be said until all the facts are in. George Crile knew that he would have been dead a long time before that would come to pass. He preferred to think out loud; to offer the results of experiments as soon as he had satisfied himself they were correct; then to revise his hypothesis and to peer into the future. I once heard William Porter, the great physiologist say, that Crile's greatest contribution to Experimental Surgery was that he kept so many surgeons and physiologists busy trying to refute his observations.

Early in 1926, his book, *The Bipolar Theory of Living Processes*, was published by Macmillan Company and stirred quite a furor. Dr. Jack Yates of Milwaukee wrote one of the most encouraging notes that a man of this temperament could have possibly received.

"You won't care a single, little, puny damn for the jeerings of the unimaginative, hard-headed, practical but ignorant clinicians or for the destructive criticism of the equally narrow-minded, ultra-scientific poseurs. Your central conception is naturally sound; the details will take care of themselves as knowledge grows. And may God have mercy on your soul."

Fortunately, we find scattered throughout the book frank appraisals of the characteristics and surgical skill of the other leaders who made American Surgery what it is today—Murphy, Ochsner, Roswell Park, Halstead, Cushing, William, Charles Mayo, Coffey, Victor Horsley, Kocher, Moynihan, and others. These comments make a distinct contribution to the understanding of the times and the men who made them.

In addition to being the husband of a wonderful woman who understood and who could help, and her family, his and their own children, Doctor Crile was blessed by having throughout his whole life two loyal professional associates—Frank Bunts and William Lower. With them he shared all of his successes and his disappointments. These three men supplemented each other in almost every way.

The development of group clinics in this country came about merely as a means to strengthen the hands of unusually successful surgeons, thereby making it so that they would do just that much more work. As a solution to the social problems connected with medical care, they have not made any important contributions. As an assembly line for surgical care, they have made many outstanding contributions to surgical efficiency. So it is not the story of the Cleveland Clinic that has meaning in this story. In its character, this contribution is no different from that of the contribution of the "Crile forceps" which sold by the millions. It is the firm of "*Bunts, Crile, and Lower*" that tells the important professional story that could mean a great deal to our young physicians and interns.

Outstanding among the other lessons which this great biography teaches us is that good experimental research can only be conducted by a man whose mind has been sensitized. Thousands of other young physicians were seeing men die of crushed legs and arms but only George Crile reacted. The death of his friend, William Lyndman, compelled him to try to find the explanation through experiment after experiment throughout the rest of his life.

George Crile was a great surgeon; a great student, but one who dared to venture out into the unexplored. He was great by the supreme test of a surgeon—he could train young men to become great surgeons.

Above all else for which we owe this great man, we owe him for these records, notes, and writings with which his devoted wife has painted for us, an accurate picture of the times. For the life of me, I cannot understand the Ohio physician who has not time to read this fascinating story. We who are interested in recording the local medical history of Ohio are doubly indebted for these two volumes.

—JONATHAN FORMAN, M.D.

Suggestions for Physicians Regarding Various Tax Law Procedures, Returns, Payments, and Deductions

EVERY person whose gross income for 1947 was \$500 or more, must file certain income tax returns with the Collector of Internal Revenue for his district, not later than March 15.

While the accompanying information concerning the Federal income tax is authentic, and based on material supplied by Mr. S. F. Noggle, Columbus, for many years chief of Income Tax for the 11th Ohio Internal Revenue District, The Journal urges that every physician obtain advice and assistance from competent legal or tax authorities or from staff members in the offices of the District Collectors of Internal Revenue in the preparation of his return. With the high rates and possible penalties involved, it is most important that everyone file returns that are prepared accurately and with care.

Proposed tax reduction measures now before Congress will not affect the individual's tax bill for income received during 1947; therefore, it is useless to postpone filing of returns pending action on these measures. When and if this legislation is passed, any reduction may possibly be retroactive to begin with the first month of 1948, and in such event would affect the entire 1948 income.

FORMS AND PAYMENTS

Not later than March 15, 1948, every physician who comes within the provisions of the Income Tax Law, must do the following:

1. File an actual return, on Form 1040, for 1947.

2. Pay the difference, if any, between the income tax paid during 1947, based on the estimated return for 1947 which he filed during that year and the amount of the tax computed on his final return for 1947 filed on or before March 15, 1948. If he has overpaid, the excess amount will be refunded or credited against future tax payments. Amounts refunded carry interest at six per cent from March 15, 1948, to date of payment.

3. File a declaration of estimated tax for the year 1948, and pay one fourth of the estimated tax for 1948, the balance payable quarterly thereafter. Blanks for filing the 1948 return have been mailed to taxpayers of record by the district collectors of internal revenue. If estimated returns for 1948 are based on 1947 income and the tax computed at the 1948 rates, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

THOSE PAID A SALARY

Any individual whose earnings are subject to withholding, e. g., a physician in a salaried posi-

tion, and whose earnings are not in excess of \$5,000, may elect to make return simply by supplying the information required on the withholding receipt furnished by his employer, W-2, (rev.), and forwarding the original copy to the office of the district collector. The tax will be computed and any amount due over the withholding will be assessed against the taxpayer, or if the withholding is in excess of the actual tax due, a refund of the overpayment will be made. Returns showing an overpayment will be processed more quickly if filed on Form 1040.

REPORT ON FUNDS PAID

While it is necessary this year to report salaries of office assistants and other employees whose salaries are subject to the withholding tax, as in previous years payments in excess of \$500 made during 1947 for interest, rents or commissions, not subject to withholding and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15, 1948, to the Commissioner of Internal Revenue, Processing Division, Kansas City, Mo.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue, Customs Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke,

Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

THOSE IN MILITARY SERVICE

A physician who is on active military duty should file his income tax return in the office of the Collector of Internal Revenue of the district in which he was a legal resident immediately prior to his entrance into active service. Compensation received for military service is subject to income tax.

DEDUCTIBLE ITEMS

In computing net income the following items may be deducted by a physician from gross income:

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation

of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held not to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in attending medical conventions for a professional purpose are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicines, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals, and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have

proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i.e., all fees, either cash or account are included in income reported for tax purposes) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible.

Sales Tax payments may be deducted. A reasonable allowance will be permitted in proportion to the physician's income. Should the claimed exemption appear too large, however, the burden of proof falls upon the taxpayer, and he may be called upon to produce purchase receipts to substantiate his claims. Sales tax coupons are not considered sufficient evidence.

The Ohio Gasoline Tax is deductible to the extent of four cents per gallon. If a physician has already deducted the cost of gasoline used in making professional calls as automobile expense, he can not of course make an additional deduction of four cents per gallon for gasoline so used. However, he may deduct that amount on gasoline purchased for other than professional use.

All license fees which the physician is required to pay are deductible, including the narcotic tax, automobile license tag fee, local occupational taxes, etc.

Under the present Income Tax, such Federal taxes as amusement taxes, and taxes on club dues and long distance telephone tolls are no longer deductible items. However, deductions may be made for taxes on telephone tolls covering calls for business or professional purposes, and which calls are in themselves, deductible as business expense.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Interest—Amounts paid out as interest upon indebtedness (except interest paid to carry non-taxable securities) are deductible.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair is claimed as a deduction.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible.

Contributions, Gifts, Etc.—It is permissible to deduct from gross income contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 15 per cent of the adjusted gross income.

Optional Standard Deduction—Under the present law a taxpayer may elect, in lieu of listing ordinary deductions such as contributions, interest and taxes, to take advantage of the optional standard deduction. On incomes in excess of \$5,000 the optional standard deduction is \$500. If the adjusted gross income is less than \$5,000, the taxpayer may elect to use the table on Page 4 of income tax return Form 1040.

Medical and Dental Expenses—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of five per cent of the adjusted gross income. In the case of a husband and wife filing a joint return, the expenses are not deductible unless they exceed five per cent of the aggregate adjusted gross income of both. The maximum allowable deduction on a joint return or the return of a head of a family is \$2,500, and for a single person, \$1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function

of the body (including amounts paid for accidents or health insurance)".

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully. It is imperative that accurate records of receipts and expenditures be maintained. Such records, in all cases where investigation by the Internal Revenue Department is made, work to the advantage of the taxpayer.

A special deduction of \$500 is allowable to a taxpayer who was blind on July 1, 1947.

OLD AGE BENEFITS TAX

The Old Age Benefits Tax is payable by every physician who employs one or more persons in his office. The employer must contribute one per cent on the first \$3,000 of each employee's wage, and a like amount is deducted from the wages of each employee. The tax return and informational return, combined in one report, Form SS-1-A, is to be filed quarterly. The tax must be paid and the return filed prior to April 30, 1948, for the months of January, February and March, 1948, in the office of the District Collector of Internal Revenue, and quarterly thereafter, payable the month after the quarter ends.

UNEMPLOYMENT COMPENSATION TAX

Under the Ohio Unemployment Compensation Law, physicians who employ three or more persons must file an "Employer's Contribution, Form UCO-2-e, Report", and Form BUC-475X report of individual worker's wages, quarterly with the Ohio Bureau of Unemployment Compensation, Columbus. Contribution reports for any calendar quarter are due within the month immediately following the quarter. The tax, which must accompany the return, amounts to 2.7 per cent of the quarterly payroll, unless qualified for a modified rating, known as the experience rating.

Employers of eight or more persons in 20 weeks during a calendar year, under the Federal Unemployment Excise Tax, must have filed with the District Collector of Internal Revenue on Form 940, prior to January 31 of each year, a report of wages paid during the preceding year.

The tax is three per cent, less a credit amounting to 90 per cent of the Federal tax if the employer of eight or more has paid his contributions in full to the Ohio Bureau of Unemployment Compensation. In effect, any such employer

whose state tax liability is paid in full need pay a rate of only three-tenths of one per cent under the Federal tax act.

OHIO USE TAX

The Ohio Use Tax Law, passed in 1936, supplementing the Retail Sales Tax Law, imposes a tax on the same basis as the sales tax, on purchases made outside the state. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department. However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15, 1948, for purchases during the period January 1 to March 31, 1948, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return".

OHIO PERSONAL PROPERTY TAX

There have been no fundamental changes in the Ohio Personal Property Tax provisions.

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31, annually. One half the amount of the tax is paid when the return is filed, and the other half is due September 20.

The State Tax Commissioner is currently conducting a campaign to increase efficiency in the collection of this tax, and penalties are being assessed against those who have been delinquent or have failed to declare personal property for taxation.

All intangible personal property in possession of a physician on January 1, 1948, and tangible personal property (not real estate) used by him in his business, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies, etc.

Such returns should be made in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which

are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments".

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced".

As the first step in making his return under the section relating to credits, a physician should estimate by his best judgment the **Actual Value** of his current accounts receivable—the amount that probably can be collected.

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1947 return he would be permitted to return as of "no value" accounts receivable which he listed in 1946 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1946 but which have decreased in actual value during the past year.

Health Center Journal Published at University

A new scientific periodical was launched at the Ohio State University on Dec. 1 with publication of the first issue of *The Health Center Journal*, by faculties of the Colleges of Medicine and Dentistry.

Scientific material in the journal is edited by Dr. Allan C. Barnes, chairman of the department of obstetrics and gynecology. Associate editors are Drs. Hamilton B. G. Robinson, D. D. S., Jonathan Forman, editor of *The Ohio State Medical Journal*, Wendell D. Postle, D. D. S., and Charles A. Doan, dean of the College of Medicine.

Editorial board members include Drs. George M. Curtis, Grant O. Graves, Benjamin C. Houghton, Paul C. Kitchin, D. D. S., Russel G. Means, Milton M. Parker, George H. Ruggy, Emmerich von Haam, Warren E. Wheeler, and Robert M. Zollinger.

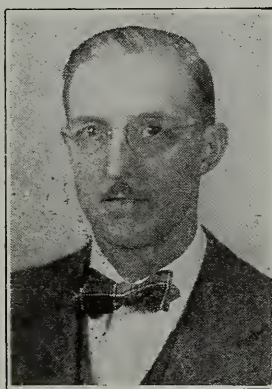
City Income Taxes

At least two Ohio cities, Toledo and Columbus, have city income taxes on a withholding basis. Information concerning these taxes may be obtained at the executive offices of the Academy of Medicine of Toledo and Lucas County or the Columbus Academy of Medicine.

Dr. Swett Named 8th District Councilor To Succeed Dr. Tronstein

Elected by The Council of the Ohio State Medical Association December 14, Dr. Chester P. Swett, Lancaster, is the Association's new Eighth

District Councilor, to succeed Dr. Arthur J. Tronstein, Newark, who has resigned to begin a two-year residency in dermatology at Cincinnati General Hospital.



DR. C. P. SWETT

Engaged in the general practice of medicine at Lancaster since 1944, Dr. Swett is a fellow of the American Medical Association; past-president of the Fairfield County Medical Society; a fellow of the American College of Chest Physicians; member of the Fairfield County Board of Health; and a director of the Fairfield County Tuberculosis and Health Association.

He is a graduate of the Trudeau School of Tuberculosis; member of Phi Chi Medical Fraternity; Alpha Omega Alpha Honorary Medical Fraternity; the Methodist Church; Masonic Lodge; and the Lions Club.

A native of Albany, Athens County, Ohio, Dr. Swett received his premedical education at Ohio University, and was graduated from Jefferson Medical College, Philadelphia, in 1925. He served a year's rotating internship at Harrisburg (Pa.) Hospital, two years' residency at the Pennsylvania State Sanatorium, Mount Alto, Pa., and a year at Essex Mountain Sanatorium, Verona, New Jersey. For three and one half years he was first assistant physician at Pawling Sanatorium, Troy, New York.

He was engaged in the general practice of medicine at Logan, Ohio, for 18 months, and for eight years at Sugar Grove, and moved to Lancaster in 1944. He and his wife, Margaret, and two sons, Russell Jackson, 14, and Chester, Jr., 8, reside at 228 Lake Street in Lancaster.

County Society Presidents and Secretaries Invited to Conference in Columbus on Sunday, February 22

A NNUAL Conference of Presidents and Secretaries of the County Medical Societies of Ohio with the officers and committeemen of the Ohio State Medical Association will be held on Sunday, February 22, at the Fort Hayes Hotel, 31 West Spring Street, Columbus.

The conference will open at 9:30 a.m. with registration and get-acquainted session. The sessions proper will convene in the Gold Room, Second Floor.

At 9:45 a.m., Dr. R. L. Rutledge, Alliance, President, State Association, will welcome the County Society officers and officials and members of committees of the State Association.

SCHOOL HEALTH

First address on the program will be by Dr. Thomas E. Shaffer, Columbus, school physician, University School, Ohio State University, who will speak on "Medical Leadership in School Health Programs".

This question is one of widespread importance, requiring immediate consideration and action by all County Medical Societies. A Committee on School Health is being established by the State Association to formulate guiding policies and principles, to cooperate with the local societies, and to carry on activities in this field on a state-wide basis. Activities now being undertaken in the field of school health will be reviewed by Dr. Shaffer and recommendations for local action will be offered.

CANCER CONTROL

Another question of state-wide interest and importance will be discussed by Dr. John H. Lazzari, Cleveland, chairman, Cancer Committee, Ohio State Medical Association. Dr. Lazzari will talk on "Role of the County Medical Society in Cancer Control". The responsibility of the County Medical Society in giving professional guidance to cancer control and education activities in the community; how detection centers should be operated and other details regarding cancer programs will be reviewed.

DISTRICT CONFERENCES

At 11:00 a.m., the conference will be broken up into Councilor District Conferences. These will give the local officers an opportunity to get better acquainted with their respective Councilor, to discuss local problems and activities with the Councilor, and to draft questions to be submitted to the question-and-answer session in the afternoon.

LUNCHEON AT 12:30

A complimentary luncheon will be served at 12:30 p.m. Reservations for the luncheon in ad-

vance of the meeting will be required from the local presidents and secretaries and officials and committeemen of the State Association. Cards for this purpose have been mailed to those invited to the conference.

PUBLIC HEALTH ACTIVITIES

Following the luncheon, the subject, "What Can Be Done to Improve Ohio's Local and State Health Departments?" will be discussed by Dr. John D. Porterfield, Columbus, Director, Ohio Department of Health. It is anticipated that Dr. Porterfield will review some of the current financial and personnel problems confronting the health departments of the state and offer suggestions on solutions. How the County Medical Societies of the state can help in strengthening public health activities in Ohio will be discussed.

V.A. MEDICAL PROGRAM

The final address will be made by Dr. M. J. Werner, Cincinnati, chief medical officer, Cincinnati Regional Office of the Veterans Administration. His subject will be: "Policies and Procedures of the Veterans Administration Medical Care Program". Dr. Werner will review the rules and regulations governing the Ohio plan of providing medical care for veterans with service-connected disabilities and attempt to clarify the misunderstandings and complications which have arisen in some areas.

"INFORMATION PLEASE"

From 3:00 p.m. to 4:00 p.m., an "Information Please" session will be staged. Written questions and those presented from the floor will be submitted to the program participants for answering. Officials of the State Association will be prepared to answer questions on subjects other than those covered by the program.

RESERVATIONS FOR LUNCHEON REQUIRED

As stated invitations have been sent to the officers of all County Medical Societies and to officers and committeemen of the State Association. Those receiving invitations should immediately return the luncheon reservation card, if they have not already done so, in order that the proper number of luncheon places can be laid.

Official Program ~ ~ ~ ~ ~

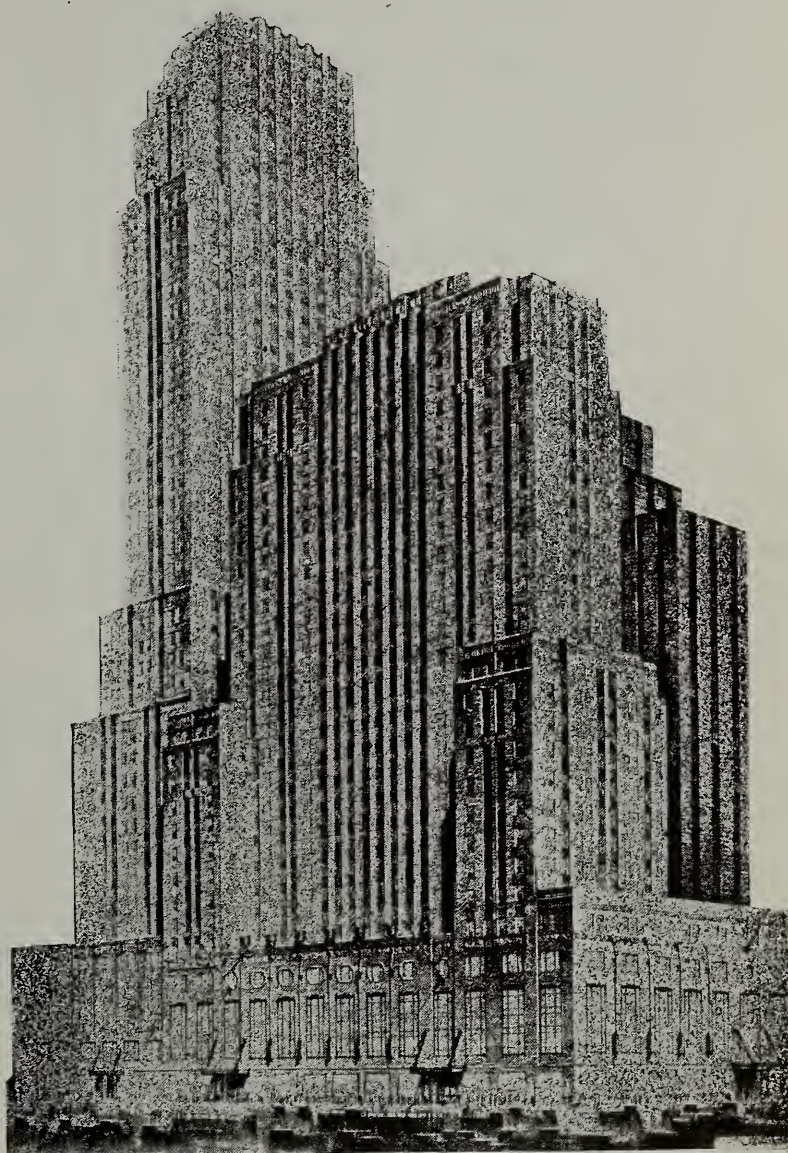
1948 ANNUAL MEETING

OHIO STATE
MEDICAL
ASSOCIATION



MARCH 30 - APRIL 1

CINCINNATI, O.



NETHERLAND PLAZA

ON this and the following pages will be found detailed information on the program and schedule of events for the 1948 Annual Meeting of the Ohio State Medical Association.

TIME AND PLACE: Tuesday, Wednesday, and Thursday, March 30, March 31, and April 1; Netherland Plaza and Hotel Gibson, Cincinnati, Ohio.

REGISTRATION: Registration Headquarters, Fourth Floor, Netherland Plaza. Opening daily at 8:00 A.M. and closing daily at 6:00 P.M., except on Thursday, April 1,

when closing hour will be 3:00 P.M. No registration charge. Admission to all sessions will be by badge secured at Registration Headquarters. Those eligible to register: Members of the Ohio State Medical Association (who should have 1948 membership card for presentation at time of registration); physicians from other states who are members of their state medical society; residents, interns, medical students, nurses, health workers, and others who are presented at Registration Headquarters by a member.



SCIENTIFIC SESSIONS: Most of the scientific and clinical sessions will be held in the Netherland Plaza; a few at the Hotel Gibson. See detailed program.

HOUSE OF DELEGATES: First session of the House of Delegates will be a dinner meeting, March 30, 6:30 P.M., Hall of Mirrors, Netherland Plaza. The second session will be a luncheon meeting, April 1, 12:30 P.M., Hall of Mirrors, Netherland Plaza.

SCIENTIFIC EXHIBIT: What promises to be the largest and finest Scientific Exhibit ever presented by the Ohio State Medical Association will be housed in the Pavillon Caprice, Fourth Floor, Netherland Plaza. Inspection of all the 40 or more educational displays should be a "must" item on the schedule of each person attending the meeting. Open daily from 9:00 A.M. to 6:00 P.M., except Thursday, April 1, when closing time will be 2:00 P.M.

TECHNICAL EXHIBIT: Consisting of 58 displays of pharmaceuticals, equipment, books, etc., the Technical Exhibit will be housed in the North and South Exhibit Halls, adjacent to the Hall of Mirrors, Fourth Floor, Netherland Plaza. It will be open daily from 9:00 A.M. to 6:00 P.M., except on Thursday, April 1, when closing time will be 2:00 P.M.

INSTRUCTIONAL COURSES: This feature which aroused a great deal of favorable comment during the 1947 Annual Meeting will be repeated at the Cincinnati meeting. The Instructional Courses will follow the line of panel discussions, with



a moderator and discussants, on some of the current medical and surgical problems which confront today's physician in his daily practice. They will be informal in character. Every effort will be made to make them practical. Time will be allowed for answering questions submitted in writing or from the floor. Admission will be by card only. Cards may be obtained in advance of the meeting on application to the Columbus Office, Ohio State Medical Association. There will be no charge. Attendance at each course will be limited to 100 persons, or fewer, in most instances. A first-come, first-served policy will prevail in issuing the tickets. A folder, with card for applying for Instructional Course tickets, will be mailed to each member well in advance of the dates of the meeting.

ANNUAL BANQUET: The Hall of Mirrors, Netherland Plaza, will be the scene of the Annual Banquet on Wednesday evening, March 31, 7:30 P.M. Formal dress optional. No speeches. Program of music and entertainment, to be followed by dancing. Tickets at \$5.00 each will be available in advance of the meeting on application, accompanied by check, to Columbus Office, Ohio State Medical Association, and during the meeting at the Registration Headquarters. It may be necessary to limit attendance, so tickets should be ordered by mail to insure a place at this top social event of the meeting.

SPECIAL TELEPHONE SERVICE: Special telephone service for physicians attending the meeting will be maintained at the Netherland Plaza near the Registration Headquarters, through the courtesy of the Cincinnati Academy of Medicine.

Instructional Courses

SIX DAILY FROM 1:30 P.M. TO 3:00 P.M.—HOW MEMBERS MAY SIGN UP FOR COURSES IN ADVANCE OF THE MEETING

ONE of the features of the 1948 Annual Meeting will be the series of Instructional Courses to be given daily from 1:30 to 3:00 P.M. at the Netherland Plaza.

These courses will provide members with practical instruction on the handling of clinical problems arising in everyday practice—especially in the general practice of medicine.

Specially-selected clinicians will serve as moderators and as participants in the informal discussions. Following the panel discussions, time will be allowed for questions and answers.

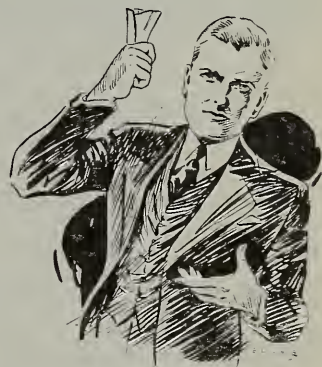
Eighteen courses will be presented—six different courses each day of the meeting. See detailed daily programs for Instructional Course topics and participants.

Attendance at the Instructional Courses will be limited. **Admission will be by ticket only.** Therefore, those planning to attend the Instructional Courses should apply for tickets in advance of the meeting.

A special folder on the Instructional Courses and other Annual Meeting events will be mailed to each member in the near future. Read the folder carefully as it will give you information on how to secure Instructional Course tickets.

An application card for ordering Instructional Course tickets will accompany the folder. This card should be filled out, per instructions, and mailed to the Columbus Headquarters Office where applications will be filled. They will be filled in the order received—on a first-come, first-served basis. It would be advisable to secure Instructional Course tickets by mail, to insure admission to the courses desired. **Tickets will be mailed to those who apply, well in advance of the meeting.** There will be no registration fee for the courses. In fact there is no registration fee for any of the scientific sessions.

Tickets for the Annual Banquet may be ordered by mail also. This may be done at the same time Instructional Course tickets are ordered. The special folder will give details on this feature.



SCIENTIFIC EXHIBITS

THE Scientific Exhibit will be housed in the Pavillon Caprice, Fourth Floor, Netherland Plaza, adjacent to the Registration Headquarters. It will be open daily from 9:00 A.M. to 6:00 P.M. except on Thursday, April 1, when the exhibit will close at 2:00 P.M.

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The Department of Surgery, University of Cincinnati, College of Medicine, Cincinnati		DIAGNOSIS OF STERILITY	23
CANCER CLINIC, JEWISH HOSPITAL, CINCINNATI	3	Dr. Allan C. Barnes, Ohio State University, Columbus	
Dr. Alfred M. Glazer, Cincinnati		RADIOGRAPHIC ASPECTS OF BLOOD DYSCRASIAS	24
LOW BACK PAIN	4	Dr. Joseph L. Morton, Ohio State University, Columbus	
Dr. Joseph A. Freiberg and Dr. Robert Perlman, Cincinnati		VAGOTOMY	25
INFORMATION ON VETERANS ADMINISTRATION MEDICAL CARE PROGRAM	5	Dr. R. M. Zollinger, Dr. Stanley O. Hoerr, and Dr. R. S. McCleery, Ohio State University, Columbus	
U.S. Veterans Administration		FIBROUS DYSPLASIA OF BONE	26
STREPTOMYCIN IN THE TREATMENT OF TUBERCULOSIS	6	Dr. Hans G. Schlumberger, Ohio State University, Columbus	
Tuberculosis Unit, Veterans Administration Center, Dayton		HYPERSPLENISM	27
THE INDUSTRIAL COMMISSION OF OHIO	7	Dr. C. A. Doan, Dr. Emmerich von Haam, and Dr. B. K. Wiseman, Ohio State University, Columbus	
Medical Section, Ohio Industrial Commission, Columbus		U.S. ARMY MEDICAL DEPARTMENT	28
ACTIVITIES OF THE OHIO STATE MEDICAL ASSOCIATION	8	Dr. Edward M. Gunn, Army Institute of Pathology, Washington, D.C.	
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VASCULAR CHANGES IN THE SKIN IN PREGNANCY	10	Engineering Division, Air Material Command, Dayton	
Dr. William B. Bean, Department of Medicine, University of Cincinnati, College of Medicine, Cincinnati		THE CAUSES OF HEMATURIA	31
RESPIRATORY ACIDOSIS AND ALKALOSIS	11	Dr. Parke G. Smith and Dr. John W. Hauser, Cincinnati	
Dr. Samuel Spector and Dr. Charles F. McKhann, Babies' and Children's Hospital, Cleveland		GEOGRAPHIC REGISTRATION OF THE HEART CYCLE	32
CARE OF CHILDREN WITH RHEUMATIC HEART DISEASE	12	Dr. Dale P. Osborn and Dr. J. R. Schmidt, Cincinnati	
Children's Heart Association, Cincinnati		TANTALUM CRANIOPLASTY	33
JUVENILE DIABETES: MANAGEMENT WITH UNRESTRICTED DIETARY REGIME	13	Dr. W. J. Gardner and Dr. E. C. Weiford, Cleveland Clinic, Cleveland	
Dr. G. M. Guest, Dr. W. Brodsky, and Mrs. J. Garvin, Children's Hospital, Cincinnati		PREVENTION AND TREATMENT OF PENICILLIN REACTIONS	34
PUNCH BIOPSY OF THE LIVER	14	Dr. Milton D. Feldman, Department of Dermatology, Cincinnati General Hospital, Cincinnati	
Gastric Laboratory, Department of Internal Medicine and Department of Pathology, Cincinnati General Hospital, Cincinnati		X-RAY AS AN AID IN THE DIFFERENTIAL DIAGNOSIS OF OBSTRUCTIVE AND NONOBSTRUCTIVE JAUNDICE	35
CEREBRAL ANGIOGRAPHY	15	Dr. Samuel A. Brown, Dr. J. E. McCarthy, and Dr. Archie Fine, Jewish and Good Samaritan Hospitals, Cincinnati	
Dr. Frank H. Mayfield, Dr. Edgar S. Lot-speich, Jr., and Dr. James R. Simpson, Cincinnati		GLAUCOMA—ITS DANGER CANNOT BE OVERESTIMATED	36
SOME ECZEMATOGENIC PLANTS OF OHIO, KENTUCKY, AND INDIANA	16	Dr. Donald J. Lyle, Dr. Mary Knight-Asbury, and Dr. Karl W. Ascher, Department of Ophthalmology, Cincinnati General Hospital, Cincinnati	
Dr. Karl G. Zwick, Cincinnati		EXHIBIT BY THE MEDICAL DEPARTMENT OF THE U.S. NAVY: OPERATION CROSSROADS	37
APPENDICEAL CALCULI	17	Dr. C. A. Swanson, Surgeon General, U.S. Navy	
Dr. Benjamin Felson, X-Ray Department, Cincinnati General Hospital, Cincinnati		BRONCHOGRAPHY IN CHILDREN	38
SEROLOGIC TESTS IN SYPHILIS	18	Dr. Charles S. Blase and Dr. Eugene L. Saenger, Children's Hospital, Cincinnati	
Dr. Philip Wasserman, Jewish Hospital, Cincinnati		CRIME PAYS	39
ENDOCRINE GYNECOLOGY	19	Dr. Frank R. Dutra, Office of the Hamilton Coroner, Cincinnati	
Dr. E. Perry McCullagh, Dr. Robert W. Schneider, and Dr. H. Kammer, Cleveland Clinic, Cleveland		LARGE TISSUE SECTIONS IN THE STUDY OF TUMORS	40
PAPANICOLAOU TECHNIQUE	20	Dr. Chas. M. Barrett, Dr. Edward A. Gall, and Dr. Max M. Zinninger, Cincinnati General Hospital and Bethesda Hospital, Cincinnati	
Dr. Douglas P. Graf, Department of Surgery, Cincinnati General Hospital, Cincinnati			
UTERINE CANCER DIAGNOSIS BY CERVICAL SMEARS	21		
Dr. George M. Wilcoxon, University Hospitals, Cleveland			

Good Food

Good Music

Good Entertainment

Good Dancing

A GALA occasion is being arranged for Wednesday evening, March 31, for those attending the 1948 Annual Meeting of the Ohio State Medical Association in Cincinnati.

On that evening the Annual Banquet will be held in the beautiful Hall of Mirrors of the Netherland Plaza, starting at 7:30 o'clock. Formal dress will be optional.

Tickets for the banquet will cost \$5.00 each and may be purchased in advance through the Columbus Headquarters Office, or at the Registration Headquarters during the first day and a half of the meeting.

The special Annual Meeting folder which will be mailed to all members in advance of the meeting will contain detailed information regarding the purchase of tickets by mail. An order blank and envelope for mailing it to Columbus will accompany the folder.

Since it may be necessary to limit the sale of tickets in accord with the seating capacity of the banquet hall, members should order banquet tickets by mail, if possible, to insure admission to this big social event.

The program for the evening will be 100 per cent entertainment and fun. There will be no speeches.

While the guests dine on the de luxe food for which the Netherland Plaza is famous, there will be soft dinner music by a string quartet and maybe, as a surprise, a few vocal numbers of the semi-classical variety.

Top entertainment of the evening will be furnished by the internationally known "Card Detective", Michael MacDougall. For 18 years, Mickey MacDougall has been tracking down the uppercrust of the underworld—polished, flowery-mannered sharpers who cheat at cards, dice, roulette, and other "come-ons" for the unwary. Out of his experiences, MacDougall has developed an astounding entertainment feature. His hands are like lightning. He performs incredible feats with cards, dice, and other gambling gimmicks. While demonstrating how the pros fleece the uninitiated, Mickey tells in his own pungent manner, stories of gamblers and of his own experiences in cooperating with law-enforcement authorities in breaking up these rackets.

Following the MacDougall performance, there will be dancing until 1:00 A.M. with one of Cincinnati's dance bands furnishing the tunes.

You can't afford to miss this delightful evening. Get your tickets early.



MICHAEL MacDOUGALL



1948—ANNUAL

OHIO STATE MEDICAL ASSOCIATION

TUESDAY, MARCH 30

TIME	SECTION ON MEDICINE		SECTION ON ANESTHESIOLOGY
9:00 A.M. to 12:00 Noon	Hall of Mirrors, Fourth Floor Netherland Plaza <i>(See following pages for details)</i>		Parlors A, B, C, D, Fourth Floor Netherland Plaza <i>(See following pages for details)</i>
12:00 Noon to 1:30 P.M.	RECESS FOR LUNCHEON		
1:30 P.M. to 3:00 P.M.	Instructional Course 1 Parlors A and B, Fourth Floor Netherland Plaza MANAGEMENT OF ACUTE CARDIOVASCULAR PROBLEMS A. CARLTON ERNSTENE, M.D. Cleveland, Moderator <i>(See following pages for details)</i>	Instructional Course 2 Parlor G, Fourth Floor Netherland Plaza MANAGEMENT OF DIARRHEAS IN CHILDREN KATHARINE DODD, M.D. Cincinnati, Moderator <i>(See following pages for details)</i>	Instructional Course 3 Parlors C and D, Fourth Floor Netherland Plaza SUPPURATIVE DISEASES OF THE CHEST M. A. BLANKENHORN, M.D. Cincinnati, Moderator <i>(See following pages for details)</i>
3:15 P.M. to 3:45 P.M.	INVESTIGATION OF DEATHS IN THE INTERESTS OF PUBLIC SAFETY ALAN R. MORITZ, M.D. Boston, Mass.		
3:50 P.M. to 4:20 P.M.	THE TREATMENT OF SELECTED CASES OF BONE SARCOMA BY RESECTION AND BONE TRANSPLANTATION Dallas B. Phemister, M.D. Chicago, Ill.		
4:25 P.M. to 5:05 P.M.	PRESENT STATUS OF SURGERY OF THE HEART AND ASSOCIATED GREAT VESSELS B. Noland Carter, M. D. Cincinnati		
6:30 P.M.	DINNER FOR MEMBERS OF THE HOUSE OF DELEGATES AND THE FIRST		

MEETING—1948

NETHERLAND PLAZA AND HOTEL GIBSON, CINCINNATI

TUESDAY, MARCH 30

SECTION ON OBSTETRICS AND GYNECOLOGY

Ballroom, Second Floor

Hotel Gibson

(See following pages for details)

AND VISITING THE EXHIBITS

Instructional Course 4

Parlor H, Fourth Floor
Netherland Plaza

ACUTE HEAD INJURIES

W. JAMES GARDNER, M.D.
Cleveland, Moderator

*(See following pages
for details)*

Instructional Course 5

Parlors E and F,
Fourth Floor
Netherland Plaza

CHEMOTHERAPY IN MEDICAL PRACTICE

MAURICE A.
SCHNITKER, M.D.
Toledo, Moderator

*(See following pages
for details)*

Instructional Course 6

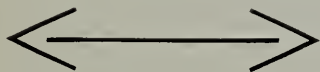
Parlor I, Fourth Floor
Netherland Plaza

TREATMENT OF BURNS AND THERMAL SHOCK

VINTON E. SILER, M.D.
Cincinnati, Moderator

*(See following pages
for details)*

FIRST GENERAL SESSION



HALL OF MIRRORS, FOURTH FLOOR
NETHERLAND-PLAZA

BUSINESS SESSION, HALL OF MIRRORS, FOURTH FLOOR, NETHERLAND PLAZA

1948—ANNUAL

OHIO STATE MEDICAL ASSOCIATION

WEDNESDAY, MARCH 31

TIME 9:00 A.M. to 12:00 Noon	SECTION ON GENERAL PRACTICE OF MEDICINE Hall of Mirrors, Fourth Floor Netherland Plaza <i>(See following pages for details)</i>	SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE Parlors A, B, C, D, Fourth Floor Netherland Plaza <i>(See following pages for details)</i>	
12:00 Noon to 1:30 P.M.	RECESS FOR LUNCHEON		
1:30 P.M. to 3:00 P.M.	Instructional Course 7 Parlors A and B, Fourth Floor Netherland Plaza SURGICAL EMERGENCIES FRED M. DOUGLASS, M.D. Toledo, Moderator <i>(See following pages for details)</i>	Instructional Course 8 Parlor G, Fourth Floor Netherland Plaza PEPTIC ULCERATION AND ITS MANAGEMENT LEON SCHIFF, M.D. Cincinnati, Moderator <i>(See following pages for details)</i>	Instructional Course 9 Parlors C and D, Fourth Floor Netherland Plaza ACCIDENTS DURING PARTURITION RICHARD D. BRYANT, M.D. Cincinnati, Moderator <i>(See following pages for details)</i>
3:15 P.M. to 3:45 P.M.	CONSERVATISM IN THE SURGERY OF THE UTERUS AND THE OVARIES Bayard Carter, M.D. Durham, N.C.		
3:50 P.M. to 4:20 P.M.	PITFALLS IN ROENTGEN EXAMINATION OF THE GASTRO-INTESTINAL TRACT Merrill C. Sosman, M.D. Boston, Mass.		
4:25 P.M. to 5:05 P.M.	HEADACHE MECHANISMS Harold G. Wolff, M.D. New York, N.Y.		
7:30 P.M.	ANNUAL BANQUET, HALL OF MIRRORS,		

MEETING—1948

NETHERLAND PLAZA AND HOTEL GIBSON, CINCINNATI

WEDNESDAY, MARCH 31

SECTION ON EYE, EAR, NOSE AND THROAT

Victory Room, Lower Lobby
Hotel Gibson

AND VISITING THE EXHIBITS

<p>Instructional Course 10</p> <p>Parlor H, Fourth Floor Netherland Plaza</p>	<p>Instructional Course 11</p> <p>Parlors E and F, Fourth Floor Netherland Plaza</p>	<p>Instructional Course 12</p> <p>Parlor I, Fourth Floor Netherland Plaza</p>
<p>EMERGENCIES ARISING IN THE DIABETIC PATIENT</p> <p>THOMAS P. SHARKEY, M.D. Dayton, Moderator</p> <p><i>(See following pages for details)</i></p>	<p>PRACTICAL MANAGEMENT OF ARTERIAL HYPERTENSION</p> <p>IRVINE H. PAGE, M.D. Cleveland, Moderator</p> <p><i>(See following pages for details)</i></p>	<p>VIRUS INFECTIONS AND THEIR MANAGEMENT</p> <p>N. PAUL HUDSON, M. D. Columbus, Moderator</p> <p><i>(See following pages for details)</i></p>



SECOND GENERAL SESSION

HALL OF MIRRORS, FOURTH FLOOR

NETHERLAND PLAZA

THIRD FLOOR, NETHERLAND PLAZA

OHIO STATE MEDICAL ASSOCIATION

THURSDAY, APRIL 1

TIME	SECTION ON SURGERY	SECTION ON NERVOUS AND MENTAL DISEASES	
9:00 A.M. to 12:00 Noon	Hall of Mirrors, Fourth Floor Netherland Plaza <i>(See following pages for details)</i>	Parlors A, B, C, D, Fourth Floor Netherland Plaza <i>(See following pages for details)</i>	
12:00 Noon	RECESS FOR LUNCHEON		
12:30 P.M.	LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND FINAL		
1:30 P.M. to 3:00 P.M.	Instructional Course 13 Parlor G, Fourth Floor Netherland Plaza INJURIES TO THE ANKLE AND WRIST JOHN A. CALDWELL, M.D. Cincinnati, Moderator <i>(See following pages for details)</i>	Instructional Course 14 Parlors A and B, Fourth Floor Netherland Plaza INTESTINAL OBSTRUCTIONS M. M. ZINNINGER, M.D. Cincinnati, Moderator <i>(See following pages for details)</i>	Instructional Course 15 Parlor H, Fourth Floor Netherland Plaza INFECTIONS OF THE HAND DONALD M. GLOVER, M.D. Cleveland, Moderator <i>(See following pages for details)</i>

MEETING—1948

NETHERLAND PLAZA AND HOTEL GIBSON, CINCINNATI

THURSDAY, APRIL 1

SECTION ON PEDIATRICS

Ballroom, Second Floor
Hotel Gibson

(See following pages for details)

AND VISITING THE EXHIBITS

BUSINESS SESSION, HALL OF MIRRORS, FOURTH FLOOR, NETHERLAND PLAZA

Instructional Course 16

Parlors C and D,
Fourth Floor
Netherlands Plaza

THE ACUTE LOWER ABDOMINAL CONDITIONS IN WOMEN

LESTER J.
BOSSERT, M.D.
Cincinnati, Moderator

*(See following pages
for details)*

Instructional Course 17

Parlor I, Fourth Floor
Netherlands Plaza

ANESTHESIA AND ANALGESIA IN OBSTETRICS

GLEN K. FOLGER, M.D.
Cleveland, Moderator

*(See following pages
for details)*

Instructional Course 18

Parlors E and F,
Fourth Floor
Netherlands Plaza

RESUSCITATION
B. B. SANKEY, M.D.
Cleveland, Moderator

*(See following pages
for details)*

TUESDAY, MARCH 30

9:00 A.M.

SECTION ON MEDICINE

Hall of Mirrors, Fourth Floor
Netherland Plaza

PROGRAM COMMITTEE

Ralph M. Watkins, M.D., Cleveland, Section
Chairman
Leon Schiff, M.D., Cincinnati, Section Secretary
T. P. Sharkey, M.D., Dayton
Phillip T. Knies, M.D., Columbus
F. W. Anzinger, M.D., Springfield

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:30

ANTIBIOTICS—SOME OF THEIR LIMITATIONS
Morton Hamburger, M. D., Cincinnati.

9:30 to 10:00

ENDOCRINE ASPECT OF MALIGNANT TUMORS
Gray H. Twombly, M.D., New York, N.Y.

10:00 to 10:15

CURABLE FORMS OF HEART DISEASE

A. Carlton Ernstene, M.D., and William L.
Proudfit, M.D., Cleveland.

10:15 to 10:30

PERIPHERAL VASCULAR DISEASE

Louis G. Herrmann, M.D., Cincinnati.

10:30 to 10:35

RECESS

10:35 to 12:00

PANEL DISCUSSION

Moderator: Leon Schiff, M.D., Cincinnati.
Discussants: A. Carlton Ernstene, M.D., Cleve-
land; Morton Hamburger, M. D., Cincinnati;
Louis G. Herrmann, M.D., Cincinnati; Wil-
liam L. Proudfit, M.D., Cleveland; Gray H.
Twombly, M.D., New York, N.Y.

12:00 to 1:30

**RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS**

TUESDAY, MARCH 30

9:00 A.M.


SECTION ON ANESTHESIOLOGY

Parlors A, B, C, D, Fourth Floor
Netherland Plaza

PROGRAM COMMITTEE

R. J. Whitacre, M.D., Cleveland, Section
Chairman
Carl R. Damron, M.D., Mansfield, Section Sec-
retary
A. L. Schwartz, M.D., Cincinnati
Paul L. Yordy, M.D., Dayton
George F. Collins, M.D., Columbus

**Visit the Taft Museum While
At Annual Meeting**

 FFICIALS of the Taft Mu-
seum, 316 Pike Street, Cin-
cinnati, have extended a cor-
dial invitation to members of the
Ohio State Medical Association and
their wives and guests to visit the
museum at the time of the Annual
Meeting in Cincinnati.

The Taft Museum is one of Amer-
ica's most distinguished historic
houses and exhibits one of the coun-
try's best known art collections. It
offers without charge, lectures and
tours of the institution and the spe-
cial exhibitions on display.

9:00 to 9:15

BUSINESS MEETING

9:15 to 10:15

PANEL DISCUSSION—CURARE

Moderator: J. K. Potter, M.D., Cleveland.

1. Indications for Use—Stuart C. Cullen,
M.D., Iowa City, Iowa.
2. Curare-like Agents—J. J. Jacoby, M.D.,
Columbus.
3. Dangers of Curare—Frank A. Oldenburg,
M.D., Akron.

10:15 to 11:00

**THE USE OF INTRAVENOUS PENTOBARBITAL
SODIUM**

Stuart C. Cullen, M.D., Iowa City, Iowa.

11:00 to 12:00

PANEL DISCUSSION—INHALATION THERAPY

Moderator: A. L. Schwartz, M.D., Cincinnati.

1. Oxygen Therapy—F. W. Brosius, M.D.,
Middletown.
2. Carbon Dioxide—Adolph Shor, M.D., Cin-
cinnati.
3. Positive Pressure — Philip Katz, M.D.,
Toledo.

12:00 to 1:30

**RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS**

TUESDAY, MARCH 30

9:00 A.M.

**SECTION ON OBSTETRICS AND
GYNECOLOGY**

Ballroom, Second Floor
Hotel Gibson

PROGRAM COMMITTEE

J. L. Reycraft, M.D., Cleveland, Section
Chairman
Richard D. Bryant, M.D., Cincinnati, Section
Secretary
Ralph K. Ramsayer, M.D., Canton
George M. Wilcoxon, M.D., Alliance
Allan C. Barnes, M.D., Columbus

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:30

CANCER DETECTION

George M. Wilcoxon, M.D., Alliance.

9:30 to 10:00

Rh FACTOR IN OBSTETRICS

Edith L. Potter, M.D., Chicago, Ill.

10:00 to 10:15

GERIATRIC GYNECOLOGY

Ralph W. Eddy, M.D., Cincinnati.

10:15 to 10:30

PRACTICE OF ENDOCRINOLOGY

Allan C. Barnes, M.D., Columbus.

10:30 to 10:35

RECESS

10:35 to 12:00

PANEL DISCUSSION

Moderator: J. L. Reycraft, M. D., Cleveland.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

TUESDAY, MARCH 30

1:30 to 3:00 P.M.

Netherland Plaza

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

1. MANAGEMENT OF ACUTE CARDIOVASCULAR PROBLEMS

Parlors A and B, Fourth Floor
Moderator: A. Carlton Ernstene, M.D., Cleve-
land.

2. MANAGEMENT OF DIARRHEAS IN CHILDREN

Parlor G, Fourth Floor
Moderator: Katharine Dodd, M.D., Cincinnati.

3. SUPPURATIVE DISEASES OF THE CHEST

Parlors C and D, Fourth Floor
Moderator: M. A. Blankenhorn, M.D., Cin-
cinnati.

4. ACUTE HEAD INJURIES

Parlor H, Fourth Floor
Moderator: W. James Gardner, M.D., Cleve-
land.

Stag Smoker For Neurologists and Psychiatrists, March 30

A STAG SMOKER for all physicians who will attend the meeting of the Section on Nervous and Mental Diseases of the Ohio State Medical Association during the Annual Meeting in Cincinnati will be given on Tuesday evening, March 30, with the Cincinnati Society of Neurology and Psychiatry as host.

The smoker will start at 8:00 P.M. and will be held on the boat of the Army and Navy Club, foot of Lawrence Street and the Ohio River.

Physicians interested in these specialties are cordially invited, and urged, to attend this social event, Dr. Howard W. Fabing, chairman of arrangements, has announced.

5. CHEMOTHERAPY IN MEDICAL PRACTICE

Parlors E and F, Fourth Floor
Moderator: Maurice A. Schnitker, M.D., Toledo.

6. TREATMENT OF BURNS AND THERMAL SHOCK

Parlor I, Fourth Floor
Moderator: Vinton E. Siler, M.D., Cincinnati.

TUESDAY, MARCH 30

3:15 P.M.

FIRST GENERAL SESSION

Hall of Mirrors, Fourth Floor
Netherland Plaza

3:15 to 3:45

INVESTIGATION OF DEATHS IN THE INTERESTS OF PUBLIC SAFETY

Alan R. Moritz, M.D., Boston, Mass.

3:50 to 4:20

THE TREATMENT OF SELECTED CASES OF BONE SARCOMA BY RESECTION AND BONE TRANSPLAN- TATION

Dallas B. Phemister, M.D., Chicago, Ill.

4:25 to 5:05

PRESENT STATUS OF SURGERY OF THE HEART AND ASSOCIATED GREAT VESSELS

B. Noland Carter, M.D., Cincinnati.

TUESDAY, MARCH 30

6:30 P.M.

HOUSE OF DELEGATES

DINNER FOR MEMBERS OF THE HOUSE OF
DELEGATES AND FIRST BUSINESS SESSION

Hall of Mirrors, Fourth Floor
Netherland Plaza

WEDNESDAY, MARCH 31

9:00 A.M.

SECTION ON GENERAL PRACTICE

Hall of Mirrors, Fourth Floor
Netherland Plaza

PROGRAM COMMITTEE

Emil R. Swepston, M.D., Cincinnati, Section
Chairman
J. G. Lemmon, M.D., Akron, Section Secretary
S. D. Nielsen, M.D., Elyria
L. E. Anderson, M.D., Greentown
Neil Millikin, M.D., Hamilton

9:00 to 9:15

BUSINESS MEETING

9:15 to 10:00

**ROUND-TABLE DISCUSSION—CHRONIC ECZEMATOID
ERUPTIONS ON THE HANDS**

Moderator: Leon Goldman, M.D., Cincinnati.

10:00 to 10:30

DESIRABILITY OF BREAST FEEDING THE INFANT

Wyman C. C. Cole, M.D., Detroit, Mich.

10:30 to 10:45

RECESS

10:45 to 12:00

**ROUND-TABLE DISCUSSION—IMMUNIZATION IN IN-
FANTS AND PRE-SCHOOL CHILDREN**

Moderator: Charles F. McKhann, M.D., Cleve-
land.

12:00 to 1:30

**RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS**

WEDNESDAY, MARCH 31

9:00 A.M.

**SECTION ON PUBLIC HEALTH AND
PREVENTIVE MEDICINE**

Parlors A, B, C, D, Fourth Floor
Netherland Plaza

PROGRAM COMMITTEE

Harold J. Knapp, M.D., Cleveland, Section
Chairman
Wm. B. Wild, M.D., Massillon, Section Secretary
Floyd P. Allen, M.D., Cincinnati
Ollie M. Goodloe, M.D., Columbus
John D. Porterfield, M.D., Columbus

9:00 to 9:15

BUSINESS MEETING

MEDICINE AND THE CHANGING ORDER

9:15 to 9:45

1. INTERNATIONAL TRENDS IN MEDICAL CARE
John B. Grant, M.D., New York, N.Y.

9:45 to 10:00

2. PREVENTIVE MEDICINE

Benjamin C. Houghton, M.D., Columbus.

10:00 to 10:15

3. PERSONAL MEDICINE

Roger E. Heering, M.D., Columbus.

10:15 to 10:30

4. GERIATRICS

Harley A. Williams, M.D., Cleveland.

10:30 to 10:45

5. INDUSTRIAL MEDICINE

Robert A. Kehoe, M.D., Cincinnati.

10:45 to 10:50

RECESS

10:50 to 12:00

PANEL DISCUSSION

Moderator: Jonathan Forman, M.D., Columbus.

12:00 to 1:30

**RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS**

WEDNESDAY, MARCH 31

9:00 A.M.

SECTION ON EYE, EAR, NOSE AND THROAT

Victory Room, Lower Lobby
Hotel Gibson

PROGRAM COMMITTEE

Russel G. Means, M.D., Columbus, Section
Chairman
Horace W. Reid, M.D., Cincinnati, Section
Secretary
Ralph M. Miller, M.D., Cincinnati
Norvil A. Martin, M.D., Gallipolis
S. C. Yinger, M.D., Springfield

9:00 to 9:20

**RELATIONSHIP BETWEEN TONSILLECTOMIES AND
POLIOMYELITIS IN CUYAHOGA COUNTY, OHIO**

Charles E. Kinney, M.D., Cleveland.

General Discussion—5 minutes.

9:25 to 9:45

MANAGEMENT OF STRABISMUS

Arthur M. Culler, M.D., Columbus.

General Discussion—5 minutes.

9:50 to 10:10

**ABUSES AND USES OF ANTIBIOTICS IN EAR, NOSE,
AND THROAT**

Henry M. Goodyear, M.D., Cincinnati.

General Discussion—5 minutes.

10:15 to 10:30

ACQUAINTANCESHIP PERIOD

10:30 to 10:50

Report of the Secretary. Nominating Com-
mittee Report. Election of Officers. Re-

quested report of the chairman as to the division of this section into two independent sections of (1) Ophthalmology; (2) Otorhino-laryngology. General discussion and action on the foregoing as to future policies.

10:50 to 11:05

VISUAL AND HEARING TESTING NOW REQUIRED BY LAW IN OUR SCHOOLS

John D. Porterfield, M.D., D.P.H., Columbus
Director, Ohio Department of Health.
Question-and-answer period—5 minutes.

11:10 to 11:15

AN INFORMATIVE REPORT OF THE OHIO DEPARTMENT OF WELFARE'S PROGRAM FOR PREVENTION OF BLINDNESS, THE REHABILITATION OF THE VISUALLY HANDICAPPED, AND CARE OF THE BLIND

Claude S. Perry, M.D., Columbus
Consultant to the Ohio Commission for the Blind.

11:15 to 11:45

SURGICAL TREATMENT OF GLAUCOMA AND ITS COMPLICATIONS

Derrick T. Vail, M.D., Chicago, Ill.

11:45 to 12:00

GENERAL DISCUSSION

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING THE EXHIBITS

WEDNESDAY, MARCH 31

9:00 A.M.

**ANNUAL MEETING OF
OHIO STATE RADIOLOGICAL SOCIETY**

Hotel Gibson

Ralph W. Holmes, M.D., Chillicothe.....President
Henry Snow, M.D., Dayton.....Vice-President
Carroll C. Dundon, M.D., Cleveland
Secretary-Treasurer

9:00 to 9:30

AN ACADEMY OF MEDICINE PLAN FOR THE DIAGNOSIS OF UTERINE CANCER BY THE PAPANICOLAOU METHOD OF CYTOLOGICAL STUDY

Edward L. Burns, M.D., Toledo.

9:30 to 10:15

VENOUS CATHETERIZATION OF THE HEART

Merrill C. Sosman, M.D., Boston, Mass.

10:15 to 10:45

SOME ROENTGEN AND SURGICAL CONSIDERATIONS OF PULMONARY LESIONS

Charles M. Barrett, M.D., and Edward J. McGrath, M.D., Cincinnati.

10:45 to 11:15

RADIOGRAPHIC DIAGNOSIS OF CONGENITAL HEART DISEASE

John Douglas, M.D., Cleveland.
Discussion by Merrill C. Sosman, M.D., Boston, Mass.

11:30 to 12:30

FILM-READING SESSION

Merrill C. Sosman, M.D., Boston, Mass., Presiding.

1:00 P.M.

Luncheon for members of the Society and guest speakers, to be followed by annual business meeting and election of officers.

WEDNESDAY, MARCH 31

**ANNUAL MEETING OF OHIO CHAPTER,
AMERICAN COLLEGE OF CHEST PHYSICIANS**

Hotel Gibson

W. L. Potts, M.D., Columbus.....President
William J. Habeeb, M.D., Springfield
Vice-President
Garry G. Bassett, M.D., Lakewood
Secretary-Treasurer

12:00 Noon

Luncheon.

1:30 P.M.

PNEUMOPERITONEUM IN THE TREATMENT OF PULMONARY TUBERCULOSIS

Myron M. Perlich, M.D., Cleveland.

WEDNESDAY, MARCH 31

1:30 to 3:00 P.M.

Netherland Plaza

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

7. SURGICAL EMERGENCIES

Parlors A and B, Fourth Floor
Moderator: Fred M. Douglass, M.D., Toledo.

8. PEPTIC ULCERATION AND ITS MANAGEMENT

Parlor G, Fourth Floor
Moderator: Leon Schiff, M.D., Cincinnati.

9. ACCIDENTS DURING PARTURITION

Parlors C and D, Fourth Floor
Moderator: Richard D. Bryant, M.D., Cincinnati.

10. EMERGENCIES ARISING IN THE DIABETIC PATIENT

Parlor H, Fourth Floor
Moderator: Thomas P. Sharkey, M.D., Dayton.

11. PRACTICAL MANAGEMENT OF ARTERIAL HYPERTENSION

Parlors E and F, Fourth Floor
Moderator: Irvine H. Page, M.D., Cleveland.

12. VIRUS INFECTIONS AND THEIR MANAGEMENT

Parlor I, Fourth Floor
Moderator: N. Paul Hudson, M.D., Columbus.

WEDNESDAY, MARCH 31

3:15 P.M.

SECOND GENERAL SESSION

Hall of Mirrors, Fourth Floor
Netherland Plaza

3:15 to 3:45

CONSERVATISM IN THE SURGERY OF THE UTERUS
AND THE OVARIES

Bayard Carter, M.D., Durham, N.C.

3:50 to 4:20

PITFALLS IN ROENTGEN EXAMINATION OF THE
GASTRO-INTESTINAL TRACT

Merrill C. Sosman, M.D., Boston, Mass.

4:25 to 5:05

HEADACHE MECHANISMS

Harold G. Wolff, M.D., New York, N.Y.

WEDNESDAY, MARCH 31

7:30 P.M.

ANNUAL BANQUET

Hall of Mirrors, Third Floor
Netherland Plaza

MUSIC ENTERTAINMENT
DANCING

THURSDAY, APRIL 1

9:00 A.M.

SECTION ON SURGERY

Hall of Mirrors, Fourth Floor
Netherland Plaza

PROGRAM COMMITTEE

J. Edwin Purdy, M.D., Canton, Section
Chairman
Robert M. Zollinger, M.D., Columbus, Section
Secretary
Vinton E. Siler, M.D., Cincinnati
Max T. Schnitker, M.D., Toledo
Frederick T. Merchant, M.D., Marion

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:30

SOME PHASES OF POSTOPERATIVE CARE IN GALL-
BLADDER DISEASE

Gordon G. Nelson, M.D., Youngstown

9:30 to 10:00

FLUID BALANCE IN SURGICAL PATIENTS

Walter G. Maddock, M.D., Chicago, Ill.

10:00 to 10:15

POSTOPERATIVE CARE AFTER ILEOSTOMY

John M. Walker, M.D., Dayton.

10:15 to 10:30

POSTOPERATIVE MANAGEMENT OF PATIENTS WITH
GASTRECTOMY

MacDonald Wood, M.D., Cincinnati.

10:30 to 10:45

HEPARIN/PITKIN'S MENSTRUUM IN THE TREATMENT
OF THROMBOSIS

Curtis Artz, M.D., Columbus.

10:45 to 11:00

NUTRITIONAL PROBLEMS WITH SPECIAL REFER-
ENCE TO HYPOPROTEINEMIA IN SURGICAL PATIENTS

Frederick R. Mautz, M.D., Cleveland.

11:00 to 11:15

EARLY AMBULATION IN POSTOPERATIVE PATIENTS

Harold P. Shapiro, M.D., Toledo.

11:15 to 11:30

ANTIBIOTICS AND POSTOPERATIVE PULMONARY
COMPLICATIONS

Stanley O. Hoerr, M.D., Columbus.

11:30 to 12:00

PANEL DISCUSSION—POSTOPERATIVE CARE OF
PATIENTS

Moderator: Robert M. Zollinger, M.D., Co-
lumbus.

12:00 to 1:30

RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS

THURSDAY, APRIL 1

9:00 A.M.

**SECTION ON NERVOUS AND MENTAL
DISEASES**

Parlors A, B, C, D, Fourth Floor
Netherland Plaza

PROGRAM COMMITTEE

Philip Piker, M.D., Cincinnati, Section Chairman
Dwight M. Palmer, M.D., Columbus, Section
Secretary
Harrison S. Evans, M.D., Columbus
A. T. Hopwood, M.D., Cambridge
E. O. Harper, M.D., Cleveland

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:40

EXPERIENCES WITH BIFRONTAL LOBOTOMY

Harry E. Lefever, M.D., Columbus.
Discussants: Frank Mayfield, M.D., Cincinnati;
Laurence M. Weinberger, M.D., Akron.

9:40 to 10:05

ELECTROCOMA THERAPY. A SIX-YEAR FOLLOW-UP
STUDY

J. L. Fetterman, M.D., Cleveland; Victor M.
Victorhoff, M.D., Cleveland; and Elaine Ben-
jamin, A.B. (by courtesy).
Discussants: Douglas Goldman, M.D., Cincin-
nati; George T. Harding, M.D., Columbus.

10:05 to 10:30

**EMOTIONAL FACTORS IN THE PATIENT WITH
DIABETES MELLITUS**

I. Arthur Mirsky, M.D., Cincinnati.
Discussants: Douglas M. Bond, M.D., Cleveland;
Cecil Striker, M.D., Cincinnati.

10:30 to 10:35

RECESS

10:35 to 11:00

**PSYCHOLOGICAL FACTORS IN WOMEN WITH
PEPTIC ULCERS**

Frederic T. Kapp, M.D., Cincinnati; Edward
Kezur, M.D., Cincinnati; Milton Rosenbaum,
M.D., Cincinnati.

Discussants: A. R. Vonderahe, M.D., Cincinnati;
Eugene B. Ferris, Jr., M.D., Cincinnati.

11:00 to 11:25

**RECENT ADVANCES IN RESEARCH AND TREATMENT
OF MULTIPLE SCLEROSIS**

I. Mark Scheinker, M.D., Cincinnati.
Discussants: Charles D. Aring, M.D., Cincinnati;
Howard D. McIntyre, M.D., Cincinnati.

12:00 to 1:30

**RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS**

THURSDAY, APRIL 1

9:00 A.M.

SECTION ON PEDIATRICS

Ballroom, Second Floor

Hotel Gibson

PROGRAM COMMITTEE

W. B. Taggart, M.D., Dayton, Section Chairman

John Edwin Brown, Jr., M.D., Columbus, Section Secretary

Hugh Wellmeier, M.D., Piqua

George C. Malley, M.D., Zanesville.

Robert A. Lyon, M.D., Cincinnati

9:00 to 9:15

BUSINESS MEETING

9:15 to 9:30

VIRUS PULMONARY INFECTION

Richard G. Hodges, M.D., Cleveland.

9:30 to 9:45

PYARTHROSIS IN INFANCY

J. Victor Greenebaum, M.D., Cincinnati.

9:45 to 10:00

**TREATMENT OF CONGENITAL SYPHILIS WITH
PENICILLIN**

Carl A. Koch, M.D., Cincinnati.

10:00 to 10:05

RECESS

10:05 to 10:35

**THE DIAGNOSIS AND SURGICAL TREATMENT OF
CONGENITAL HEART DISEASE**

Richard J. Bing, M.D., Baltimore, Md.

10:35 to 10:50

HISTOPLASMOSIS IN OHIO

Lester W. Sontag, M.D., Yellow Springs.

10:50 to 11:05

ANTIBIOTIC THERAPY IN PEDIATRICS

Harve J. Carlson, D.P.H., Cleveland.

11:05 to 12:00

PANEL DISCUSSION

Moderator: (To be selected).

12:00 to 1:30

**RECESS FOR LUNCHEON AND VISITING
THE EXHIBITS**

THURSDAY, APRIL 1

12:30 P.M.

HOUSE OF DELEGATES

**LUNCHEON FOR MEMBERS OF THE HOUSE OF
DELEGATES AND FINAL BUSINESS SESSION**

Hall of Mirrors, Fourth Floor
Netherland Plaza

THURSDAY, APRIL 1

1:30 to 3:00 P.M.

Netherland Plaza

INSTRUCTIONAL COURSES

(Admission by Ticket Only)

13. INJURIES TO THE ANKLE AND WRIST

Parlor G, Fourth Floor

Moderator: John A. Caldwell, M.D., Cincinnati.

14. INTESTINAL OBSTRUCTIONS

Parlors A and B, Fourth Floor

Moderator: M. M. Zininger, M.D., Cincinnati.

15. INFECTIONS OF THE HAND

Parlor H, Fourth Floor

Moderator: Donald M. Glover, M.D., Cleveland.

**16. THE ACUTE LOWER ABDOMINAL CONDITIONS
IN WOMEN**

Parlors C and D, Fourth Floor

Moderator: Lester J. Bossert, M.D., Cincinnati.

17. ANESTHESIA AND ANALGESIA IN OBSTETRICS

Parlor I, Fourth Floor

Moderator: Glen K. Folger, M.D., Cleveland.

18. RESUSCITATION

Parlors E and F, Fourth Floor

Moderator: B. B. Sankey, M.D., Cleveland.

TECHNICAL EXHIBITORS

NORTH AND SOUTH HALLS, FOURTH FLOOR, NETHERLAND PLAZA

Open from 9:00 A.M. to 6:00 P.M. on Tuesday, March 30, and Wednesday, March 31, and from
9:00 A.M. to 2:00 P.M. on Thursday, April 1

Exhibitor	Address	Booth No.	Exhibitor	Address	Booth No.
Abbott Laboratories, North Chicago, Ill.		29	Mead Johnson & Co., Evansville, Ind.		34, 35
Aloe Company, A. S., St. Louis, Mo.		5	Medical Protective Company, The, Fort Wayne, Ind.		6
Ayerst, McKenna & Harrison, Ltd., New York, N.Y.		10	Merrell Company, Wm. S., Cincinnati, Ohio		39
Baker Laboratories, Inc., The, Cleveland, Ohio		33	Mosby Company, C. V., The, St. Louis, Mo.		7
Borden Company, The, New York, N.Y.		38	Parke, Davis & Company, Detroit, Mich.		13
Bowman Bros. Drug Co., The, Canton, Ohio		36, 37	Pelton & Crane Company, The, Detroit, Mich.		4
Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N.Y.		51	Pet Milk Sales Corporation, St. Louis, Mo.		21, 22
Camel Cigarettes, New York, N.Y.		57, 58	Philip Morris & Co., Ltd., Inc., New York, N.Y.		17
Cameron Surgical Specialty Co., Chicago, Ill.		32	The Procter and Gamble Company, Cincinnati, Ohio		45
Carnation Company, Milwaukee, Wis.		18	Safety First Supply Company, Pittsburgh, Pa.		16
Ciba Pharmaceutical Products, Inc., Summit, N.J.		12	Saunders Company, W. B., Philadelphia, Pa.		1
Coca-Cola Company, The, Atlanta, Ga.		41, 42	Schering Corporation, Bloomfield, N.J.		11
Columbus Hospital Supply Co., Columbus, Ohio		15	Searle & Co., G. D., Chicago, Ill.		43
Davis Company, F. A., Philadelphia, Pa.		56	Sharp & Dohme, Inc., Philadelphia, Pa.		30
Gerber Products Company, Fremont, Mich.		40	Smith, Kline & French Laboratories, Philadelphia, Pa.		26
"Junket" Brand Foods, Little Falls, N.Y.		3	Spencer, Incorporated, New Haven, Conn.		49
Kelley-Koett Manufacturing Company, The, Covington, Ky.		23, 24	Squibb & Sons, E. R., New York, N.Y.		9
Kinney and Sons, Inc., H. W., Columbus, Ind.		2	Templar-Thelen X-Ray Company, Cincinnati, Ohio		50
Lea & Febiger, Philadelphia, Pa.		46	U.S. Vitamin Corporation, New York, N.Y.		52
Lederle Laboratories Division, American Cyanamid Co., New York, N.Y.		20	Warren-Teed Products Company, The, Columbus, Ohio		25
Liebel-Flarsheim Co., The, Cincinnati, O.		53, 54	Wendt-Bristol Co., Columbus, Ohio		48
Lilly and Company, Eli, Indianapolis, Ind.		55	Westinghouse Electric Corp., Pittsburgh, Pa.		27, 28
Lincoln Laboratories, Inc., Decatur, Ill.		19	White Laboratories, Inc., Newark, N.J.		44
Lippincott Company, J. B., Philadelphia, Pa.		31	Winthrop-Stearns, Inc., New York, N.Y.		8
M & R Dietetic Laboratories, Inc., Columbus, Ohio		47	Wyeth Incorporated, Philadelphia, Pa.		14

WOMAN'S AUXILIARY TO MEET AT HOTEL SINTON, CINCINNATI, MARCH 30-APRIL 1, INCLUSIVE

Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held in Cincinnati at the time of the Annual Meeting of the Ohio State Medical Association—March 30-April 1, inclusive.

Headquarters of the Auxiliary meeting will be Hotel Sinton. Mrs. Dale Osborn, Cincinnati, a past-president of the State Auxiliary, is the chairman of the Local Committee on Arrangements, and Mrs. Paul Woodward, Cincinnati, president of the Cincinnati Auxiliary, is chairman of the Hostess Committee.

Among the honored guests will be the president and president-elect of the Indiana, Michigan, New York, Pennsylvania, West Virginia, and Kentucky State Auxiliaries

DELEGATES AND ALTERNATES

FIRST DISTRICT

Counties	Delegates	Alternates
ADAMS	S. J. Ellison	R. L. Lawwill
BROWN		
BUTLER	H. M. Lowell	D. M. Blizzard
	C. T. Atkinson	J. F. Borelli
CLERMONT	A. J. Mastropaolo	J. M. Coleman
CLINTON	Edmond K. Yantes	H. Richard Bath
HAMILTON	William J. Graf	Joseph G. Crotty
	Emil R. Swepton	A. Clyde Ross
	William A. Altemeier	Vinton E. Siler
	C. R. Deeds	Daniel E. Earley
	Harry L. Fry	John W. Hauser
	Edward J. McGrath	Charles H. Moore
	Stanley D. Simon	H. J. Nimitz
	Arthur W. Wendel	Robert H. Kotte
	Joseph Lindner	C. R. Rittershofer
HIGHLAND	J. Martin Byers	John G. Anderson
WARREN	O. L. Layman	John Sharts

SECOND DISTRICT

CHAMPAIGN	D. C. Houser	E. R. Earle
CLARK	D. W. Hogue	Ray M. Turner
DARKE	J. E. Gillette	G. E. Sayle
GREENE	C. G. McPherson	P. B. Wingfield
MIAMI	G. A. Woodhouse	B. M. Hogle
MONTGOMERY	M. D. Prugh	L. E. Baker
	R. Dean Dooley	Ned D. Shepard
	R. S. Binkley	R. C. Doan
	A. W. Carley	R. E. Pumphrey
PREBLE	C. E. Newbold	J. R. Williams
SHELBY	H. E. Crimm	Russell Wiessinger

THIRD DISTRICT

ALLEN	Fred P. Berlin	W. B. Light
AUGLAIZE	Elizabeth Y. Kuffner	
CRAWFORD	D. G. Arnold	D. D. Bibler
HANCOCK	Frank M. Wiseley	
HARDIN	F. M. Elliott	J. F. Holtzmuller
LOGAN	Hobart L. Mikesell	Warren F. Mills
MARION		
MERCER	E. J. Willke	George H. McIlroy
SENECA	R. F. Machamer	P. J. Leahy
VAN WERT	Chester A. Morgan	Roy E. Shell
WYANDOT		

FOURTH DISTRICT

DEFIANCE	D. J. Slosser	Paul B. Newcomb
FULTON	E. R. Murbach	R. E. Merrill
HENRY	B. L. Johnson	Thomas W. Quinn
LUCAS		
OTTAWA	G. A. Boon	Cyrus R. Wood
PAULDING	Ray Mouser	K. C. Evans
PUTNAM	W. B. Recker	John R. Echelbarger
SANDUSKY		
WILLIAMS	H. W. Wertz	H. R. Mayberry
WOOD	Paul F. Orr	F. V. Boyle

FIFTH DISTRICT

ASHTABULA	R. B. Wynkoop	P. J. Collander
CUYAHOGA		
GEAUGA	Alton W. Behm	Phillip P. Pease
LAKE	Morris G. Carmody	G. R. Smith

SIXTH DISTRICT

COLUMBIANA	J. A. Fraser	P. H. Beaver
MAHONING	Wm. M. Skipp	I. C. Smith
	E. J. Wenaas	W. J. Tims
	G. G. Nelson	R. E. Odom
PORTAGE	Walter B. Webb	R. C. Neely
STARK	R. K. Ramsayer	Harry W. Beck
SUMMIT	V. C. Malloy	W. T. Bucher
	R. E. Pinkerton	E. W. Burgner
	Kurt Weidenthal	J. D. Hayden
	L. A. Witzeman	R. E. Wetzel
TRUMBULL	Harry A. Smith	S. J. Shapiro

SEVENTH DISTRICT

BELMONT	Leo D. Covert	D. Myers Creamer
CARROLL	Joseph D. Stires	S. L. Weir
COSHOCTON	G. A. Foster	Floyd W. Craig
HARRISON	C. F. Goll	E. L. Miller
JEFFERSON	S. L. Burkhardt	Earl Rosenblum
MONROE		
TUSCARAWAS	C. M. Dougherty	J. C. Blinn

EIGHTH DISTRICT

ATHENS	L. A. Hamilton	Beatrice Postle
FAIRFIELD	L. E. Stenger	C. H. Hamilton
GUERNSEY	James A. L. Toland	J. D. Knapp
LICKING	George A. Gressle	R. G. Mannino
MORGAN	Henry Bachman	A. A. Coulson
MUSKINGUM	M. A. Loebell	C. F. Sisk
NOBLE	C. F. Thompson	Ed. Ditch
PERRY		
WASHINGTON	Ford Eddy	G. E. Huston

NINTH DISTRICT

GALLIA		
HOCKING		
JACKSON	John L. Frazer	C. C. Fitzpatrick
LAWRENCE	W. F. Marting	John A. Dole
MEIGS	R. E. Boice	F. M. Cluff
PIKE	Charles L. Critchfield	Mack E. Moore
SCIOTO	W. A. Quinn	L. D. Allard
VINTON	H. D. Chamberlain	Evelyn Ball

TENTH DISTRICT

DELAWARE	B. R. Lauer	G. J. Parker
FAYETTE	James E. Rose	E. H. McDonald
FRANKLIN	Drew L. Davies	John J. Gallen
	George J. Heer	W. L. Pritchard
	Grant O. Graves	Howard R. Mitchell
	Warren G. Harding	Thomas E. Rardin
	2nd	
	Charles W. Pavey	George F. Collins
	F. C. Hugenberger	A. Ruppertsberg, Jr.
KNOX		
MADISON	W. A. Holman	Wm. T. Bacon
MORROW	F. M. Hartsook	J. P. Ingmire
PICKAWAY	Geo. W. Heffner	H. D. Jackson
ROSS	Ralph W. Holmes	O. P. Tatman
UNION	E. J. Marsh	H. C. Duke

ELEVENTH DISTRICT

ASHLAND		
ERIE	V. A. Killoran	H. W. Lehrer
HOLMES	N. P. Stauffer	A. J. Earney
HURON	O. J. Nicholson	H. A. Erlenbach
LORAIN	John T. Fawcett	Charles R. Meek
	S. D. Nielsen	Valloyd Adair
MEDINA	W. B. Houston	T. V. Kolb
RICHLAND	John S. Hattery	George L. Evans
WAYNE	F. C. Ganyard	R. N. Wright

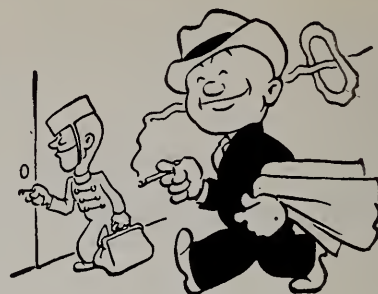
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Pres.	R. L. Rutledge	Treasurer	H. P. Worstell
		Past-Pres.	
Pres.-Elect	A. A. Brindley		Edgar P. McNamee

COUNCILORS

District		District	
First	E. O. Swartz	Seventh	Carl A. Lincke
Second	H. C. Messenger	Eighth	Chester P. Swett
Third	J. Craig Bowman	Ninth	
Fourth	Carl S. Mundy		Gilbert R. Micklethwaite
Fifth	Fred W. Dixon	Tenth	H. M. Clodfelter
Sixth	Paul A. Davis	Eleventh	Ross M. Knoble

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For the **ANNUAL MEETING**

OHIO STATE MEDICAL ASSOCIATION
in Cincinnati — March 30 thru April 1

NAME AND LOCATION	Single	Double	Double Twin Beds
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ALMS, McMillan and Victory Parkway			\$6.00-\$ 7.50
BROADWAY, Fourth and Broadway	\$3.00		\$5.00-\$ 6.00
FOUNTAIN SQUARE, Fifth and Vine	\$3.00-\$ 4.00	\$4.50-\$ 5.50	\$5.50-\$ 6.50
GIBSON, Fifth and Walnut	\$3.25-\$12.00	\$5.50-\$12.00	\$6.00-\$12.00
METROPOLE, 609 Walnut	\$2.50-\$ 6.00	\$4.00-\$10.00	\$5.00-\$10.00
PALACE, Sixth and Vine	\$1.75-\$ 3.00	\$3.50-\$ 4.00	\$4.50
SINTON, Fourth and Vine	\$3.00-\$ 8.00	\$5.00-\$ 8.00	\$6.00-\$10.00



HOTEL RESERVATION BLANK

Mail the coupon to hotel selected

Manager _____ Hotel, Cincinnati, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, March 30, 31, and April 1, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____
☐ Twin Bed Room with bath ☐ Suite

Arriving _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION:

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Predictions and Forecasts on What Congress Will Do At Present Session on Health and Medical Proposals

CHARLES S. NELSON, Executive Secretary

“IT IS AN ELECTION YEAR and members of Congress are rapidly becoming more conscious of the potency of health as a political subject.”

The above quotation from the January 5 issue of *Washington Report on the Medical Sciences* is in a sense a prophecy on the current session of the 80th U.S. Congress which convened on January 6.

There are strong indications that there will be plenty of fireworks on health and medical legislation in the present session of the Congress. Some observers are of the opinion that little, if any, health legislation of great importance will be enacted unless unusual developments occur. On the other hand, all are agreed that there will be much “speaking for the record”, especially among those who have their eyes on the election in November.

There is no doubt but what representatives of the medical profession will be kept busy following the mass of health proposals already on the docket or which will be introduced. It will be necessary to keep physicians properly and promptly informed on what is cooking in Washington; what to do in the way of letting their Representatives and Senators know how they, as physicians, feel about some of the pending bills.

WILL KEEP MEMBERS INFORMED

Through the Washington Office of the American Medical Association and from reliable legislative reporting services, the Legislative Committee of the Ohio State Medical Association will obtain information currently on the Washington scene. This information will be relayed to the Legislative Chairmen of the County Medical Societies and to the membership as a whole, whenever feasible. In this way, Ohio physicians will be kept up to date on the status of pending bills and will be advised when and how to act.

It is not necessary for Ohio physicians to look to independent medical organizations for information from Washington. Their own State Association will keep them or their local representatives advised, accurately and promptly. Moreover, they can be certain that their interests are being properly represented by officials of the Ohio State Medical Association and the American Medical Association—the organizations to which members of the Congress look for information and advice on legislative matters.

What is the outlook on health and medical legislation in the present session of the Congress? The following information and predictions have been culled from various reliable sources. Obviously, Congress may cross up the prophets, as anything can happen in an election year. Nevertheless, the situation as of the present, appears to stack up as described in the following paragraphs.

TRUMAN'S MESSAGE

Those who heard or read President Truman's state-of-the-nation message, delivered to Congress on January 7, will not need to be convinced that the President intends to detour to the left. It will be noted that his plea for enactment of a system of compulsory health insurance was one of the top-bracket sections of his speech. As one writer expressed it, the address sounded like a New Deal speech “warmed over”.

Regardless, there seems to be little likelihood of the enactment of a compulsory health insurance scheme during the present session of Congress which, it is said, will wind up if possible around June 1, prior to the Party Nominating Conventions. Obviously, S. 1320, the Wagner-Murray-Dingell Bill, or some revamped version of that measure, will have to be watched. There will be more hearings—for the record. But, affirmative action on it, or anything like it, now, seems to be remote.

There has been considerable guessing as to what will happen to S. 545, the Taft-Ball-Smith Bill. There will be additional hearings. It is reported that Senator Taft has some amendments to offer. Some have predicted that this measure, which is a voluntary plan whereby the Federal Government would offer financial assistance to states which need money to provide health and medical care for those who can't afford it, might be passed by the Senate. However, there appears to be general agreement that the House is not interested at present in approving any legislation of this kind—even the Taft Bill.

SCHOOL HEALTH MEASURES

Some kind of legislation to provide Federal financial assistance to the states in setting up better medical and health services in the public schools may be enacted. There are two bills pending—H. R. 1980 and S. 1290. These measures are not identical but similar. Each would appro-

priate \$25,000,000 annually to be allotted to the states for school health programs.

No one seems to be satisfied with these bills as they stand, but the idea has powerful backing, and they may be amended to make them acceptable to those lobbying for them. It is too early to know just what revamping will be done and whether they will be acceptable to the medical profession in their final form. Regardless, they can be regarded as a move in the direction of a national health program on a limited basis. For that reason they will have to be watched carefully.

BATTLE OVER S. 140

One of the biggest battles now on the horizon is that which will take place on proposals to create a Department of Health, Education, and Security. Such a provision is set up in S. 140 introduced by Senator Taft.

Medical organizations have opposed the bill because it would merge health with education and security—submerge health in the opinions of many. They contend a single Department of Health should be created if anything is done. On the other hand, proponents of a combined department don't like the Taft bill because it provides for administrative responsibilities by physicians. They contend there should be lay administrators with physicians acting as advisors and consultants. Whether the stalemate will be broken is anybody's guess. Also, it is anybody's guess as to just how hard Senator Taft will push for enactment of this proposal.

One well-informed observer has predicted that nothing toward creating a new department of health or a department of health, education, and security will be done at the present session because a special commission is studying the question of reorganizing the entire Executive Department and that all such legislation will be shelved until after the commission, headed by Former President Herbert Hoover, submits its findings and recommendations. At any rate, there seems to be good reason to believe that even should the Taft bill get through the Senate it will have plenty of trouble in the House—perhaps enough to put it into a coma for the time being.

AID TO HEALTH DISTRICTS

A bill being drafted by members of the Association of State and Territorial Health Officers, and endorsed by that body, will be given serious consideration. The proposal would provide for additional Federal funds to improve local health departments and to enable many local areas to put their health departments under the direction of a full-time director. The outcome of this measure is in doubt but it will get more than casual consideration. It had not been introduced up to the time of this writing.

A compromise on the creation of a National

Science Foundation appears to be in the making. It will be recalled that a bill to do this was passed by Congress last Fall but was vetoed by the President because it did not provide for appointment of the Director by the White House but by members of the Foundation's board of trustees. Everyone seems to agree that legislation of this kind should be enacted. The outcome will depend on whether differences of opinion on details can be ironed out.

Scores of other bills relating to health and medicine are in the hopper and others will be introduced. Some of them will be heard—perhaps enacted. However, the real fireworks will take place on the measures mentioned above.

TAFT ISSUES CHALLENGE

Senator Taft in a recent Associated Press interview, challenged the Democratic Party to make an issue of compulsory health insurance, observing, "I don't think the people of this country want the regimentation involved in a compulsory plan that makes every doctor subject to government regulation." His tactics in Congress may be guided by the reaction to this challenge.

If the Democratic leaders decide to put on the pressure for compulsory health insurance legislation, as demanded by President Truman, Senator Taft undoubtedly will request action on his measure—S. 545. If the move for enactment of something like the W-M-D Bill boggs down, as it has in recent sessions, Taft may not ask for a vote on his proposal.

All things considered, the safest guess would be that little, if any, legislation expanding health, welfare, and social security activities will be enacted at the current session of Congress.

There will be plenty of talking for the record. Doubtless some members of Congress would like to see a compulsory health insurance program enacted; others would favor something milder. Nevertheless, each member of Congress knows that the nation's pocketbook will be unable to stand costly domestic programs in addition to the costs of the European recovery program. Moreover, he knows that some form of tax relief legislation has become almost mandatory.

This seems to be the picture in Washington at this time. Anything can happen overnight to change it. An election year always is one of uncertainty. The year 1948 will be no different.

One thing is a certainty: The medical profession which is deeply and directly interested in the outcome of Congressional action, must be on its toes.

Through *The Journal*, the *OSMAgram*, and legislative bulletins to local society officers and legislative chairmen, the Ohio State Medical Association will keep its membership advised on developments. It will suggest action at the appropriate time.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NEW V. A. FEE SCHEDULE MAILED TO ALL MEMBERS

Copies of the new agreement, including a revised fee schedule, between the Ohio State Medical Association and the Veterans Administration, which became effective January 1, 1948, have been mailed to all members of the Association. They accompanied the *OSMAgram* dated January 12.

Read the new agreement carefully, as well as the revised fee schedule, which differs in many respects from the fee schedule which has been in effect since July 1, 1946. Note that the fee schedule should be regarded as a guide and a maximum. In billing the Veterans Administration a physician is expected to keep his fee at an amount no greater than he charges other patients for similar services but in no event to charge more than the maximum fee listed in the schedule.

For services authorized by the Veterans Administration on or after January 1, 1948, a physician may bill the V. A. in accordance with the new fee schedule providing the fees listed are no greater than his customary charge to other classes of patients. The new schedule will not apply to cases which had been authorized prior to January 1.

Members who have not signed up to participate in the Ohio veterans medical care program, who desire to do so, should communicate with the Columbus office.

Incidentally, as this issue of *The Journal* went to press an announcement was made at Washington of the appointment of Dr. Paul B. Magnuson to succeed Maj. Gen. Paul R. Hawley as chief medical director of the Veterans Administration. Dr. Magnuson, who has been on leave from the medical faculty of Northwestern University, had been serving as Hawley's right-hand man in directing the medical affairs of the V. A.

READ THE ANNUAL MEETING PROGRAM IN THIS ISSUE

In this issue appears the detailed program for the 1948 Annual Meeting in Cincinnati, March 30-April 1, inclusive.

We think you will agree that it offers excellent postgraduate opportunities for both general practitioners and specialists.

If you have not made your hotel reservations, do so at once. Rooms will be at a premium.

In the near future a special folder will be

mailed to each member, accompanied by a blank for securing tickets for the Instructional Courses and the Annual Banquet. Watch for it. Better order these tickets by mail to insure an opportunity to take part in the Instructional Courses and a place at the banquet. Doubtless the attendance at both these features will have to be limited because of limited facilities.

PROSPECTS NOT VERY ALLURING UNDER SUCH LEADERSHIP

It is reported that Chairman Wolcott of the House Banking Committee, after hearing administration spokesmen present the Truman proposed anti-inflation program, made this observation:

"In my 14 years on this committee, I have never heard so vague a program submitted. Frankly, I wouldn't know how to begin writing a bill that would do the things you ask without giving you carte blanche authority over our economy."

Those responsible for the "vague" program referred to by Mr. Wolcott are the ones who are seeking to become dictators of the health and medical services of the nation.

What would be in store for the American people under this kind of direction would not be very alluring, in our opinion.

NEW MEMBER ADDED TO THE JOURNAL STAFF

Carrying out its policy of expanding its activities and staff in order to provide better services and facilities for the entire membership, the Ohio State Medical Association on January 1 made several important changes in the staff of the Columbus Headquarters Office.

Effective January 1, Mr. R. Gordon Moore, a trained newspaper man with experience in both the editorial and business side of daily and weekly newspaper management, was employed as assistant managing editor and assistant business manager of *The Ohio State Medical Journal*.

Mr. Moore is 38 years of age; married; and the father of a small son. He is a native of Louisiana and a graduate of the School of Journalism, Louisiana State University. Following graduation he entered the weekly newspaper field and was managing editor of one of the leading weekly newspapers in his native state. In 1940, to use his own words, he wrote so earnestly about preparing to meet the coming war that he sold himself on enlisting in the Army as a private. In July, 1946, Moore was discharged in the grade

of captain. Before joining the staff of *The Journal*, he was business reporter for the *Springfield (O.) Daily News*.

The Journal considers itself fortunate in being able to secure the services of a man with the training and experience of Mr. Moore. He will gradually take over many of the responsibilities and duties in connection with publishing of *The Journal* which have been assumed by other members of the Columbus Office staff, leaving them more time for public relations, field work, and other important State Association activities.

Mr. Hart F. Page, who has served so ably as news editor and advertising manager of *The Journal* for the past two years will continue temporarily as advertising manager but will devote the greater portion of his time to assisting Mr. George H. Saville, director of the Department of Public Relations, and in field work for a number of important committees of the Association. His title will be Assistant Director of Public Relations.

This expansion of the Columbus Office staff and shift in responsibilities will enable Executive Secretary Nelson and Mr. Saville, Assistant Executive Secretary, to engage in field work among the county medical societies and to devote more time to other State Association activities, including public relations.

Time marches on! It has been marching rapidly during the past decade so far as the medical profession is concerned. Present-day problems and the mass of activities in which medical organization must participate have made it mandatory for the Ohio State Medical Association to expand its services, facilities, and personnel. By doing so it has been able to do a better job for its 7,000 members. By continuing this policy when circumstances require, it will be able to do a still better job in the future.

The issues before the profession are vital. The need for a strong, united front is imperative. Any act of omission with respect to keeping the Ohio State Medical Association properly equipped for any emergency, as well as ordinary responsibilities, would indeed be an example of short-sightedness.

In our opinion, the membership generally subscribes to the policy of expansion, progress, and initiative which has been adopted by the House of Delegates and carried out by The Council.

"REFRESHER COURSE" FOR COUNTY SOCIETY OFFICERS, FEB. 22

Special efforts have been made to make the program for the Annual Conference of County Society Presidents and Secretaries at the Fort Hayes Hotel, Columbus, on Sunday, February 22, interesting and informative.

Topics which are of current importance to all

county medical societies—at least should be—and the State Association have been scheduled for discussion. The meeting will offer an opportunity for local officers to secure information from well-informed speakers and to exchange ideas and opinions with officials and committeemen of the State Association.

Every county society should be represented at the February 22 conference. Unless the officers of county societies are up-to-date on today's happenings and developments, there is little hope for vigorous, constructive action by the local societies.

"NEW LOOK" TO WOMEN'S FEET PROTESTED

A strong protest against the "new look" so far as women's shoes are concerned is registered by Dr. Dudley J. Morton, member of the faculty of the College of Physicians and Surgeons, Columbia University, in *Hygeia*.

Dr. Morton points out that "the higher heels which women wear increase greatly their toe ailments and deformities; but in addition, by throwing body weight more strongly on the forepart of the feet, if any element of internal disorder is present, high heels magnify the disorder in direct proportion to their height".

Moreover, he debunks the idea that flat-heeled shoes cause flattened arches and other baneful defects.

Perhaps it would be too optimistic to think that anything which the doctor would say would discourage those seeking the "new look" to avoid the stilts which are now being marketed as shoes. Nevertheless, you might pass along to the women folk Dr. Morton's word of advice.

NOT GEOGRAPHY, BUT HOW BIG IS THE MAN

The Cleveland Academy of Medicine Bulletin quotes from a piece by John Mason Brown, theater critic in the *Saturday Review of Literature* in which Mr. Brown defends the city physician who is put on the grill in the play, *Allegro*.

The following quotation from Mr. Brown's article, especially the last sentence of it, is so appropriate, and true, that it merits repetition again and again:

"Integrity is not a matter of geography. Sir William Osler and Hugh Young came through the municipal pressure of Baltimore unscathed. Boston did no damage to Harvey Cushing . . . Both metropolises and the grass-roots offer their counterbalancing dangers and opportunities to doctors, precisely as they do to everyone else . . . The question is not how large or small is the place, it is how big is the man."

With the Veterans Administration —

OPENINGS are available at the Brecksville Veterans Administration Hospital for physicians desiring residency training in tuberculosis and thoracic surgery, V. A. Branch Office in Columbus has announced.

Brecksville recently was approved for residency training in tuberculosis and residency training by the Council on Medical Education and Hospitals of the American Medical Association.

Physicians may submit applications for this training to the manager of Brecksville V. A. Hospital.

* * *

Residencies in neuropsychiatry are available at the Veterans Administration Hospital in Lyons, New Jersey. The program consists of one, two, or three years' training with intensive postgraduate teaching in clinical neurology and psychiatry, psychopathology, clinical psychology, etc. Experience in female and child outpatient psychiatry is included as well as in hospital training for female patients and feeble-minded children and juvenile delinquents. The residency has been approved by the A. M. A. Council on Medical Education and Hospitals.

* * *

Nearly half of the 1,728,516 World War II veterans on disability compensation rolls on June 30 had handicaps rated at 10 percent, the minimum degree of impairment for which compensations are paid, a Veterans Administration study has disclosed. Only one in every 20 veterans was totally disabled with a 100 percent rating.

Veterans with 20 percent disabilities accounted for 12.7 percent of the total; 30 percent disabilities, 17.8 percent; 40 percent disabilities, 6.2 percent; and 50 percent disabilities, 9.4 percent. Only 5.3 percent of veterans drawing compensation payments had handicaps rated between 60 and 90 percent.

Of the total cases on the rolls, 71 percent were for disabilities resulting from general medical and surgical cases; 27.5 percent were neuropsychiatric cases; and the remaining 1.5 percent were tuberculosis cases.

* * *

The Veterans Administration has reduced the number of forms it uses for processing veterans' benefits by more than 50 per cent during the past 15 months, according to a release from the Administration's Washington Office. The cutback from 19,841 to 9,698 forms under the reduction program, known as forms control and standardization, will continue until administrative forms are reduced to a minimum of between 3,500 and 4,000 forms, the V. A. announced.

* * *

What sort of preference does a veteran get on Civil Service examinations? Can an individual

take more than one examination on the same day? These and countless other questions are currently bombarding Ohio Civil Service Commission headquarters here, Gertrude Jones, Commission Chairman, reported.

Veterans, Miss Jones says, are entitled to a preference of 20 per cent of their grade on a civil service examination provided that such a grade is 70 or better exclusive of the 20 per cent. To claim such preference, the veteran must file a certified copy of his honorable discharge with his original application blank.

In answer to another of the questions asked with amazing regularity, Miss Jones stated that applicants may take more than one examination in a given series provided that they apply for not more than one given on the same day.

* * *

About 30,000 pharmacies throughout the country, taking part in the Veterans Administration home-town pharmacy program, filled more than three-quarters of a million prescriptions for veterans during 1947, E. B. Geiger, acting chief of the V. A. pharmacy division, estimated.

COMING MEETINGS

Ohio State Medical Association, Cincinnati, March 30-April 1.

American Medical Association, Third Annual National Conference on Rural Health, Chicago, Feb. 6 and 7.

American Medical Association, Joint Meeting of Council on Medical Education and Hospitals of the A.M.A., and Advisory Board for Medical Specialties, Chicago, Feb. 8.

American Medical Association, Annual Congress on Medical Education and Licensure, Chicago, Feb 9-10.

American Medical Association Annual Meeting, Chicago, June 21-25.

American Association for the Study of Goiter, Toronto, Canada, May 6-8.

American Urological Association, Boston, May 17-20.

Mahoning County Medical Society, 19th Annual Postgraduate Assembly, Youngstown, April 14.

Michigan Postgraduate Clinical Institute, Detroit, Mar. 10-12.

National Conference on Medical Service, Chicago, Feb. 8.

Northern Tri-State Medical Association, Findlay, April 13.

Ohio Rural Health Conference, Columbus, Mar. 1 and 2.

In Memoriam

Frank Peabody Atkinson, M.D., Columbus; Ohio State University College of Medicine, 1903; aged 70; died Dec. 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Atkinson practiced medicine in Columbus for the past 15 years, prior to which he practiced in Millersport, where he was a member of the Fairfield County Medical Society from 1911 to 1923, and vice-president in 1920. He was a veteran of the Spanish-American War and World War I, and was a member of the American Legion. He also was a member of the Presbyterian Church, and the Masonic Lodge. His widow, a daughter, a sister, and five brothers survive.

Charles Grant Augustus, M.D., Dayton; Ohio State University College of Medicine, 1914; aged 60; died Jan. 4; former member of the Ohio State Medical Association and the American Medical Association. Dr. Augustus was resident staff physician at the Dayton State Hospital for the past seven years, prior to which he practiced medicine in Toledo. His widow, a son and his father survive.

Thomas Earl Burgess, M.D., Toledo; University of Michigan Medical School, 1892; aged 81; died Dec. 15; former member of the Ohio State Medical Association and the American Medical Association. Dr. Burgess practiced medicine in Toledo since 1894, although for the past five years he was in semi-retirement. He was on the local city health department staff from 1932 to 1937 and was a member of the Knights of Pythias. His widow, a son, a brother and a sister survive.

Everette Virgil Conley, M.D., Cleveland, University of Louisville School of Medicine, 1916; aged 56; died Jan. 3; former member of the Ohio State Medical Association and the American Medical Association. Dr. Conley had practiced medicine in Cleveland since 1918. His widow, a son, two sisters and two brothers survive.

Charles Nelson Cooper, M.D., Cincinnati; Hahnemann Medical College and Hospital of Philadelphia, 1885; aged 87; died Jan. 6. In spite of his age, Dr. Cooper was actively practicing medicine at the time of his death.

Chester Owen Cramer, M.D., Columbus; Ohio State University College of Medicine, 1932; aged 43; died Dec. 11; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Cramer practiced medicine in Columbus since 1933. He was a member of the Hilltop Business Association and the Kiwanis Club and was active in Y.M.C.A. work.

He had been a member of the Columbus Board of Health since March, 1947. He was a member of the Methodist Church and the Masonic Lodge. Dr. Cramer served as captain in the Army Medical Corps from 1942 to 1944, and was a member of the American Legion. His widow, a daughter, his parents, a sister and three brothers survive.

Morris Alfred Darbyshire, M.D., McComb; Starling Medical College, Columbus, 1890; aged 84; died Dec. 30; former member of the Ohio State Medical Association and the American Medical Association. Dr. Darbyshire practiced medicine in Hancock County from 1895 until about eight years ago. He was vice-president of the Hancock County Medical Society in 1919, and a delegate to the O. S. M. A. in 1918 and 1919. He was a member of the McComb board of education for 15 years, a member of the Church of Christ and the Masonic Lodge. His widow and two daughters survive.

Daniel Meeker Denman, M.D., Cincinnati; Cincinnati College of Medicine and Surgery, 1881; aged 90; died Dec. 26; member of the Ohio State Medical Association and the American Medical Association. Dr. Denman practiced medicine in Cincinnati for almost 65 years, and for many years was Probate Court alienist. He was a member of the Masonic Lodge and the Knights of Pythias. His brother, Dr. L. M. Denman, died two years ago at the age of 94.

Henry Edelstein, M.D., Cleveland; University of Wooster Medical Department, 1900; aged 76; died Jan. 1; Dr. Edelstein practiced medicine in Cleveland for several years before going into the drug business. His widow, a daughter, two brothers and two sisters survive.

Daniel Ignatius Gallagher, M.D., Lakewood; St. Louis University School of Medicine, 1924; aged 50; died Jan. 8; former member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Gallagher was on the regular staff of St. John's Hospital, Cleveland, and on the visiting staff of Lakewood Hospital. He is survived by his widow, two sons, a sister, and a brother, Dr. Farrell T. Gallagher of Cleveland.

James Hadley, M.D., Marietta; Starling Medical College, Columbus, 1891; aged 90; died Dec. 18; former member of the Ohio State Medical Association and the American Medical Association. Dr. Hadley practiced medicine in Washington and Monroe counties until his retirement from active practice many years ago. In later years he was engaged in the oil business in Marietta. He was a member of the Presbyterian

Church and the Masonic Lodge. His widow survives.

Benjamin Franklin Hambleton, M.D., Houston, Tex., University of Wooster Medical Department, Cleveland; aged 75; died Dec. 9; former member of the Ohio State Medical Association and the American Medical Association. Dr. Hambleton practiced medicine in Cleveland and in Lorain County. He served on faculties at the Cleveland College, Vanderbilt University, and Baylor University. A daughter, son, and sister survive.

Richard Fuller Henderson, M.D., Urbana; Starling Medical College, 1900; aged 71; died Jan. 1; former member of the Ohio State Medical Association and the American Medical Association, and president of the Champaign County Medical Society, 1937. Dr. Henderson practiced medicine many years in Urbana. He was a member of the Presbyterian Church. His widow, a daughter, and a sister survive.

Alfred Evan Jones, M.D., Columbus; Ohio State University College of Medicine, 1918; aged 53; died Jan. 2; former member of the Ohio State Medical Association and the American Medical Association. Dr. Jones practiced medicine for many years in Belle Center where he resided until moving to Columbus a few years ago. He was a veteran of World War I, was a member of the American Legion, the Presbyterian Church, the Masonic Lodge, and took an active interest in baseball. His widow, a son, two daughters, a brother, and three sisters survive.

Edward Payson Judd, M.D., Cleveland, Western Reserve University School of Medicine, 1931; aged 42; died Dec. 31; former member of the Ohio State Medical Association and the American Medical Association. Dr. Judd was a member of the surgical staff at Lakeside Hospital. He was a member of Alpha Omega Alpha. During World War II he was a member of the medical division of the county civilian defense organization. His widow, two sons, his mother, and a sister survive.

John Bartlett Kistler, M.D., Newcomerstown; Eclectic Medical College, Cincinnati, 1924; aged 51; died Dec. 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Kistler practiced medicine in Tuscarawas County except for the period 1935-42 when he was on the staff of the State Department of Health in Columbus. He was retired from active practice in recent years. He was a member of the Lutheran Church. His widow, two sons, and a daughter, Floride Ruth Kistler, a student at Ohio State University Medical School, survive.

Ocy May Crawford Johannes McKinley, M.D., Cleveland; University of Pittsburgh School of

Medicine, 1926; aged 51; died Dec. 17; member of the Ohio State Medical Association, a Fellow of the American Medical Association, and the National Women's Medical Society. Dr. McKinley practiced medicine for more than 20 years in Cleveland where she was on the staffs of Women's Hospital and Booth Memorial Hospital. Her husband, a daughter, and her mother survive.

John Wilson Parker, M.D., Pasadena, Calif.; Chicago Homeopathic Medical College, 1899; aged 71; died Dec. 28; former member of the Ohio State Medical Association and the American Medical Association, and secretary of the Madison County Medical Society, 1920. Dr. Parker practiced medicine formerly in London, Ohio, and was on the staff of the Ohio Industrial Commission. Upon his retirement several years ago he moved to California. He was a veteran of World War I, a member of the American Legion and the Veterans of Foreign Wars, and of the Masonic Lodge. One son and a sister survive.

Philip Lee Ring, M.D., Bellaire; Cleveland-Pulte Medical College, 1905; aged 76; died Jan. 2; former member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Ring practiced medicine for many years in Belmont County. He was a veteran of World War I, was a member of the Presbyterian Church, the Masonic Lodge, and the Kiwanis Club. He is survived by his widow, a son, Dr. Homer E. Ring of Bellaire, a daughter, four brothers, and two sisters.

Earl A. Roasberry, M.D., New London; Cleveland-Pulte Medical College, 1906; aged 64; died Dec. 9; member of the Ohio State Medical Association, a Fellow of the American Medical Association, and was vice-president of the Huron County Medical Society in 1940. Dr. Roasberry practiced medicine in New London for 41 years. He was a member of the Methodist Church. His widow, two daughters, and a son, Dr. Richard Roasberry of New London, survive.

Otto Sasse, M.D., Toledo; Boston University School of Medicine, 1878; aged 92; former member of the Ohio State Medical Association and the American Medical Association. A Toledo physician for half a century, Dr. Sasse was a member emeritus of the Academy of Medicine of Toledo and Lucas County. A daughter survives.

Richard M. Skinner, M.D., Coal Grove, Lawrence County; Cleveland University of Medicine and Surgery, 1886; aged 85; died Dec. 20.

Charles Burleigh Thomas, M.D., Cleveland; Cleveland Medical College, Homeopathic, 1891; aged 81; died Dec. 30. Dr. Thomas was a veteran of World War I, was active in the Congregational

Church; was a member of the Masonic Lodge, Woodmen of the World and the Independent Order of Foresters. A son and daughter survive.

Edgar L. Vermilya, M.D. Fremont; Toledo Medical College, 1897; aged 73; died Dec. 19; former member of the Ohio State Medical Association and the American Medical Association through 1946. He was vice-president of the Sandusky County Medical Society in 1918, president in 1919, and delegate to the Ohio State Medical Association Annual Meeting in 1925 and 1926. Dr. Vermilya practiced medicine in Fremont since 1901, for 31 years was city health commissioner and formerly was coroner of Sandusky County. One son, two daughters, two brothers, and a sister survive.

Ohio Rural Health Conference in Columbus, March 1 and 2

The Annual State Conference on Rural Health, sponsored by the Ohio Rural Health Council, will be held March 1 and 2 at the Southern Hotel in Columbus.

The conference will open at 10 a. m., March 1, with a discussion of "Hospital Facilities and Health Centers". Speakers on this topic will be Joseph W. Fichter, Master of The Ohio State Grange, who will talk on the status of the national hospital construction program; Dr. John D. Porterfield, director of the Ohio Department of Health, "Status of the State Survey and the Master Plan"; and an additional speaker, who will discuss "The Local Approach".

The conference will divide into four groups during the afternoon session and will convene to present group reports at 3 p. m.

Speakers for the dinner meeting, to be held at 6:30 p. m., will be Paul E. Landis, supervisor of health, physical education, recreation, and safety, Ohio Department of Education, who will speak on "Home and Community Health Education Program"; and J. C. McAmis, of the Tennessee Valley Authority, Knoxville, Tennessee, "Soil Minerals and Our Diets".

At 9:30 a. m., March 2, the conference will take up the problems of mental health with the following speakers scheduled: Dr. Edward J. Humphreys, Acting Commissioner of Mental Hygiene, Ohio Department of Public Welfare, on "Emotional Adaptations in Health"; Dr. A. R. Mangus, rural sociologist, Ohio State University, on findings in the Miami County mental health program; and Dr. Roger M. Gove, Piqua, director of the Upper Miami Valley Guidance Center, "The Miami County Program".

During the afternoon four group discussions will again be held, with reports to be presented at 3 p. m.

Hawley New Director of National Blue Cross-Blue Shield Groups

Jobs of coordinating the activities of the national organization of voluntary prepaid hospital service plans and of the national organization of voluntary prepaid medical care plans, sponsored by hospitals and medical societies, respectively, will be assumed on April 1 by Dr. Paul R. Hawley, who recently retired as chief medical director of the Veterans Administration.

Dr. Hawley will hold the title of chief executive officer of the Blue Cross Commission and of the Blue Shield Commission.

The announcement of the appointment was made January 10 by Dr. L. Howard Schriver, Cincinnati, president of the Blue Shield Commission, commonly known as Associated Medical Care Plans, Inc., and former president of the Ohio State Medical Association, and by R. F. Cahalane, Boston, chairman of the Blue Cross Commission, at a dinner held in Dr. Hawley's honor in Washington, D. C.

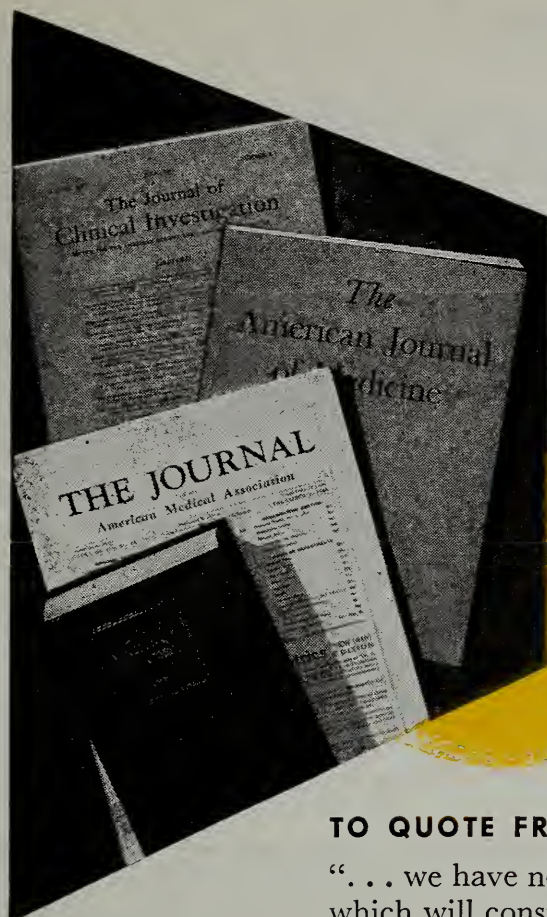
Headquarters for the newly created office will be in Chicago, from which Dr. Hawley will direct the national activities of the 91 Blue Cross plans, and the 48 non-profit medical-surgical prepayment plans. Estimated enrollment for the two groups on January 1, was 7,250,000 in the medical plans, and 29,250,000 in Blue Cross. Dr. Hawley will direct his attention to "strengthening and unifying the position of the two programs as a national movement and developing plans for national enrollment activities".

Among those who spoke at the dinner held in connection with the announcement were: Dr. Edward L. Bortz, Philadelphia, president of The American Medical Association; Roy E. Larsen, New York, president of Time, Inc., who served as toastmaster; Graham L. Davis, Battle Creek, president of the American Hospital Association; and General Carl R. Gray, Jr., administrator of Veterans' Affairs.

Dr. Hawley will continue to serve as special assistant to the Administrator of Veterans' Affairs, and as chairman of the Committee on Unification of the Medical Services of the Armed Forces until he assumes his new duties.

A graduate of the University of Cincinnati College of Medicine, Dr. Hawley was head of the medical service of the United States Army in Europe during World War II, and retired from the Army with rank of Major General, in June, 1946, to become the first Chief Medical Director of the Veterans Administration.

Dr. Robert S. Martin, Zanesville, has been elected a trustee of Muskingum College, New Concord.



Increasing recommendation for **gold therapy** in active rheumatoid arthritis

TO QUOTE FROM RECENT AUTHORITATIVE SOURCES:

"... we have not found any therapy other than gold therapy which will consistently and in a high percentage of cases change the course of the disease."¹

"Gold therapy at present seems to be the only drug which shows promise of checking the activity of rheumatoid arthritis;"²

REDUCED TOXICITY

"The high incidence of reactions attributable to the formerly employed larger doses . . . has been largely obviated by the use of more conservative doses."³ Moreover, "therapeutic results are quite as good with smaller doses...."⁴



GOLD SODIUM THIOSULFATE

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Supplied in 5 cc. (50 mg.) serum type ampuls; packages of 6, 25 and 100

CAUTION

Gold Sodium Thiosulfate must be used with extreme caution, especially in the presence of tuberculosis and diseases of the liver and kidneys.

1. Combined Staff Clinics of the College of Physicians and Surgeons, Columbia University: *Am. J. Med.* 1:675 (Dec.) 1946.
2. Comroe, B. I.: *J.A.M.A.* 128:848 (July 21) 1945.
3. Council of Pharmacy and Chem-

istry: *New and Nonofficial Remedies*, 1947, Philadelphia, J. B. Lippincott Company, 1947, p. 477.

4. Freyberg, R. H.; Block, W. D., and Levy, S.: *J. Clin. Investigation* 20:401 (July) 1941.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Do You Know? . . .

"Doctors Today", the American Medical Association's nation-wide radio program over the stations of the National Broadcasting Company, is on the air each Saturday afternoon from 4 o'clock until 4:30, over WTAM, Cleveland, and WHIZ, Zanesville. Because of a conflict, Station WLW, Cincinnati, records the program and re-broadcasts it the following Saturday at 2:30 p.m.

* * *

The Department of Psychiatry of the University of Cincinnati College of Medicine has been awarded a grant of \$175,000 by the Rockefeller Foundation, New York City. The grant covers a five-year period, and is to be used for the development of psychiatry under Dr. Maurice Levine, professor and head of the department of psychiatry.

* * *

Louis B. Blair, associated with University Hospital, Columbus, since 1942, and superintendent since 1944, has been named superintendent of St. Luke's Methodist Hospital, Cedar Rapids, Iowa.

* * *

For "outstanding work in medical research", Dr. Benjamin S. Kline, Cleveland, recently was awarded a gold medal by Phi Lambda Kappa, national medical fraternity.

* * *

Union, Madison, and Delaware counties have formed a tri-county health district, with Dr. Wayne R. Ramsey, formerly of New York City, as health commissioner.

* * *

New officers of the Ohio State Coroners' Association include Dr. Herbert P. Lyle, Cincinnati, president; Dr. Mitchell A. Spyker, Columbus, vice-president; and Dr. S. R. Gerber, Cleveland, chairman of the Board of Trustees.

* * *

George H. Saville, director of public relations, Ohio State Medical Association, explained the Association's health program for Ohio and discussed current medical and health legislation at meetings of the Kiwanis Club in Findlay, January 21, and the Lions Club in Springfield, January 22. He spoke on "Horizons" in a round-table discussion of "Modern Medical Public Relations" at the Midwest Conference of the Council on Medical Service of the American Medical Association, January 4, at Cleveland.

* * *

"Promoting Health", a new radio program by the Division of Preventive Medicine, Ohio State University College of Medicine, features staff members in talks at 6:30 p. m., each Thursday over WOSU. The "Keep Your Health" program

of the College of Medicine, has been on the air regularly for two years at 6:30 p. m., each Tuesday.

* * *

A seminar on spinal cord injuries will feature the Midwestern sectional meeting of the American Congress of Physical Medicine at the Veterans Administration Hospital, Hines, Ill., Feb. 26-27. For a copy of the program write Dr. Louis B. Newman, chief of physical medicine rehabilitation service, V. A. Hospital, Hines, Ill.

* * *

The Scientific Exhibit at the Annual Session of the American Medical Association in Chicago, June 21-25, will be held on Navy Pier.

* * *

Research grants approved recently by the National Cancer Institute of the U. S. Public Health Service include \$5,000 to the Ohio State University College of Medicine for a study of synthesis of cancer producing hydrocarbons, and \$2,500 for research on neoplasia in fishes and amphibians.

* * *

Dr. Edgar V. Allen, professor of medicine at the University of Minnesota, and chief of a section in the division of internal medicine at the Mayo Clinic, has been named chief of internal medicine at Cleveland Clinic.

* * *

Dr. H. Lee Good, for many years active in the Hamilton Y.M.C.A., has been elected an honorary life member on the board of directors of that association.

* * *

As guest lecturer on the neuropsychiatric consultants program at the School of Military Neuropsychiatry, Brooks Army Medical Center, Fort Sam Houston, Texas, Dr. Joseph L. Fetterman, Cleveland, presented papers on "Mental Mechanisms in Neuroses"; "The Treatment of Depressions with Particular Reference to Electrocoma Therapy"; and "The Treatment of Convulsive Disorders".

* * *

Dr. J. P. Gray, former dean of the School of Medicine of the Medical College of Virginia, and also of the School of Medicine, University of Oklahoma, has joined the staff of Parke, Davis & Company as medical consultant to the Sales Promotion Division.

* * *

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Officers of the Adams County Medical Society for 1948 include the following: Dr. Samuel Gendelman, Manchester, pres.; Dr. Robert B. Ellison, Peebles, pres.-elect; Dr. Hazel L. Sproull, secy.-treas.; Dr. S. L. Ellison, West Union, delegate; and Dr. R. L. Lawwill, Seaman, alternate.

BUTLER

The following physicians were elected to the offices of the Butler County Medical Society for 1948: Dr. Walter A. Reese, Middletown, pres.; Dr. Herbert Warm, Hamilton, pres.-elect; Dr. Fred W. Brosius, Middletown, secy.; Dr. Edward S. Keating, Hamilton, secy.-elect; Dr. H. M. Lowell, Hamilton, and Dr. C. T. Atkinson, Middletown, delegates; and Dr. D. M. Blizzard and Dr. J. F. Borelli, Middletown, alternates.

Dr. Thomas A. Weaver, Dayton, spoke on the treatment of head injuries, and a discussion was led by Dr. W. F. Hume, Hamilton, at a meeting of the society in the Anthony-Wayne Hotel, Hamilton, Dec. 17.

CLERMONT

Newly elected officers of the Clermont County Medical Society are: Dr. A. J. Mastropaolo, Batavia, pres. and delegate; Dr. George E. Rockwell, Milford, pres.-elect; and Dr. J. M. Coleman, Loveland, secy.-treas. and alternate.

CLINTON

Talks by M. E. Druly, Dayton, on the "Wilmington Water Supply", and by Robert Conard, Clinton County engineer, on "Drainage and Sewage of Wilmington", were given before the Clinton County Medical Society in Wilmington on Jan. 6.—R. W. DeCrow, M.D., secy.

HAMILTON

Dr. Lloyd Freeman Carver, Cornell University Medical College, spoke on, "Recent Advances in the Treatment of Lymphomas and Leukemias", before The Academy of Medicine of Cincinnati in Union Central Annex Building Jan. 6.

HIGHLAND

Members of the Highland County Medical Society elected the following officers for 1948: Dr. L. D. McBride, Hillsboro, pres.; Dr. C. G. Foor, Hillsboro, vice-pres.; Dr. W. B. Roads, Hillsboro, secy.-treas.; Dr. J. M. Byers, Greenfield, delegate; and Dr. J. Anderson, Lynchburg, alternate.

Dr. Raymond L. Hilsinger, Cincinnati, spoke on the subject, "Headaches". The society approved the form and contents of a constitution and by-laws for the proposed medical staff of the Hillsboro Hospital.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CHAMPAIGN

The following Urbana physicians were elected officers for 1948 of the Champaign County Medical Society: Dr. Ansel Woodburn, pres.; Dr. F. E. Lowry, pres.-elect; Dr. I. Miller, secy.-treas.; Dr. D. C. Houser, delegate; and Dr. E. R. Earle, alternate.

GREENE

The following officers were elected for 1948 by the Greene County Medical Society: Dr. Daniel Taylor, Yellow Springs, pres.; Dr. C. K. Schloss, Osborne, pres.-elect; Dr. P. F. McQuiggan, Xenia, secy.-treas.; Dr. C. G. McPherson, Xenia, delegate; and Dr. P. B. Wingfield, Yellow Springs, alternate.

MIAMI

"Modern Therapeutic Techniques in Neuropsychiatry", was the topic discussed by Dr. Howard D. Fabing, Cincinnati, at a joint meeting in Piqua on Jan. 15, at which the Miami County Medical Society was host to the Shelby County Medical Society. The joint meeting is an annual affair for the two societies.—G. A. Woodhouse, secy.

MONTGOMERY

Dr. Norman F. Miller, University of Michigan Medical School, spoke on, "Hysterectomy; Therapeutic Necessity or Surgical Racket", at the Jan. 9 meeting of the Montgomery County Medical Society in the Van Cleve Hotel, Dayton.

SHELBY

Dr. J. W. Tierney, Anna, was elected president of the Shelby County Medical Society, and the following Sidney physicians were elected to other offices: Dr. J. Franklin Conner, pres.-elect; Dr. John P. Marsh, secy.-treas.; Dr. H. E. Crimm, delegate; and Dr. Russell Wiessinger, alternate.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

AUGLAIZE

The 1948 officers of the Auglaize County Medical Society are: Dr. Guy E. Noble, pres. and delegate; Dr. E. Y. Kuffner, vice-pres.; Dr. W. V. Barton, secy.-treas.; all of St. Marys; and Dr. G. B. Faulder, Wapakoneta, alternate.—W. V. Barton, M.D., secy.-treas.

HANCOCK

Officers of the Hancock County Medical Society, elected for 1948 are: Dr. Lawrence H. Goodman, Findlay, pres.; Dr. Harold Treece, Arlington, pres.-elect; Dr. Thomas R. Shoupe, Findlay, secy.; Dr. Donald R. Brumley, Findlay,



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treas.; and Dr. Frank M. Wiseley, Findlay, delegate.—T. R. Shoupe, M.D., secy.

HARDIN

Dr. Robert H. Zeis, Kenton, was elected president of the Hardin County Medical Society, with the following other officers for 1948: Dr. J. A. Kramer, Ada, vice-pres.; Dr. John A. Mooney, Kenton, secy.-treas.; Dr. F. M. Elliott, Ada, delegate; and Dr. J. F. Holtzmuller, Forest, alternate.—John A. Mooney, M.D., secy.-treas.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

DEFIANCE

The following physicians were elected officers of the Defiance County Medical Society for 1948: Dr. D. G. Slosser, Defiance, pres. and delegate; Dr. J. S. Hull, Hicksville, pres.-elect; Dr. F. M. Lenhart, Defiance, secy.-treas.; and Dr. P. B. Newcomb, Defiance, alternate.—E. P. Mitchell, M.D., retiring secy.-treas.

FULTON

The following physicians were elected by the Fulton County Medical Society for 1948: Dr. R. W. Reynolds, Fayette, pres.; Dr. W. B. Ver Hey, Fayette, vice-pres.; Dr. Paul I. Geer, Metamora, secy.-treas.; Dr. E. R. Murbach, Archbold, delegate; and Dr. R. E. Merrill, Delta, alternate.—Paul I. Geer, M.D., secy.-treas.

LUCAS

"Social Changes and Their Influence on the Practice of Medicine", was the subject of an address by Dr. A. W. Adson, Rochester, Minn., before the Jan. 2 annual meeting of The Academy of Medicine of Toledo and Lucas County, in the Commodore Perry Hotel, Toledo. Dr. Franklin H. Top, of the Herman Kiefer Hospital, Detroit, Mich., spoke before the Section of Pathology, Experimental Medicine and Bacteriology of the academy on Jan. 9. His subject was, "Present Problems in Diphtheria". "Radio-Active Isotopes", was the subject of Dr. Edward Reinhard, Barnes Hospital, St. Louis, Mo., before the Medical Section on Jan. 16.

OTTAWA

Newly elected officers of the Ottawa County Medical Society for 1948 are: Dr. Cyrus R. Wood, Port Clinton, pres. and delegate; Dr. H. O. Beeman, Port Clinton, pres.-elect; Dr. Gordon R. Ley, Port Clinton, secy.-treas.; and Dr. George A. Boon, Oak Harbor, delegate.—H. O. Beeman, M.D., formerly secy.-treas.

PUTNAM

Dr. Carll S. Mundy, Toledo, Fourth District Councilor, spoke before the Putnam County Medical Society, Jan. 6, in Columbus Grove, on the subject "Current Medical Problems", and dis-

cussed present trends in national and state legislation.—H. N. Trumbull, M.D.

SANDUSKY

Officers elected by the Sandusky County Medical Society for 1948 are: Dr. J. L. Curtin, Fremont, pres.; Dr. E. C. Swint, Fremont, vice-pres.; and Dr. Harold L. Keiser, secy.-treas.—Harold L. Keiser, M.D., secy.-treas.

WILLIAMS

Members of the Williams County Medical Society elected the following officers for 1948: Dr. J. A. Maxwell, Montpelier, pres.; Dr. Richard W. Solier, Bryan, vice-pres.; Dr. P. G. Meckstroth, Bryan, secy.-treas.; Dr. H. W. Wertz, Montpelier, delegate; and Dr. H. R. Mayberry, Bryan, alternate.—Paul G. Meckstroth, M.D., secy.-treas.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

GEAUGA

Dr. Phillip P. Pease, Chardon, was elected president of the Geauga County Medical Society with the following other officers: Dr. H. E. Shafer, Middlefield, pres.-elect; Dr. Isa Teed Cramton, Burton, secy.-treas.; Dr. Alton W. Behm, Chardon, delegate. Dr. Pease also was elected alternate.—Isa Teed Cramton, M.D., secy.-treas.

In a report of the year's activities, Dr. Isa Teed Cramton, secretary of the Geauga County Medical Society, submitted the following: Dr. Robert Andrews, roentgenologist at Charity Hospital, Cleveland, and chairman of the Cancer Committee of the Academy of Medicine, addressed the meeting on April 30 on the subject of "Cancer Control", explaining the work of "The American Field Army", a woman's organization, and of "The American Cancer Society", a men's organization.

At the Aug. 20 meeting, the Geauga County Cancer Society Group reported as of Aug. 7 that \$5400 had been collected of which 50 per cent would remain in the county for use in cancer control. The matters of the County Welfare Group and schedules of fees for care of indigents and old age pensioners were discussed. On Sept. 26, members and their wives were entertained by the Lake County Medical Society at Painesville.

CUYAHOGA

Program of The Academy of Medicine of Cleveland for January was as follows:

Jan. 9—Experimental Medicine Section, "Hyperlipemia Following Infusions of Hypertonic Solutions of Sucrose", by Dr. Walter Heyman and Mary E. Hartman; "Studies on the Influence of Adrenal Cortical Steroids and Adrenotrophic Hormones on Sodium and Potassium Metabolism Using Radiosodium and Radiopotassium", by Ralph I. Dorfman, Ph.D., Betty L. Rubin, Mary L. Feil, and Albert M. Potts, Ph.D.; "Factors Deter-

mining Changes in Coronary Arterial Blood Flow Following Stimulation of Cardiac Accelerator Nerves", by Dr. R. W. Eckstein, Dr. M. W. Stroud, Dr. W. H. Prichard, and Dr. C. V. Dowl-ing; and "The Use of Microanalytical Techniques in Pediatric Practice", by Dr. Arnold Lazarow.

Jan. 14—Internal Medicine Section, "The Use of Nitrogen Mustard in the Treatment of Lym-phoblastoma", by Dr. S. M. Goldhamer, and "Folic Acid in the Treatment of Macrocytic Anemia", by Dr. R. R. Heinle.

Jan. 27—Obstetrical and Gynecological Section, "Relationship of Hypertensive State to the Oc-currence of the Separation of the Placenta", by Dr. F. Bayard Carter, Duke University.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

Columbiana County Medical Society officers for 1948 are as follows: Dr. L. C. Ziegler, Salem, pres.; Dr. Lee Bookwalter, Columbiana, pres.-elect; Dr. Julien S. Jones, Lisbon, secy.-treas.; Dr. J. A. Fraser, East Liverpool, delegate; and Dr. P. H. Beaver, Leetonia, alternate.

PORTAGE

"Plastic Surgery", was the topic of a talk by Dr. Frank L. Meany, Lakewood, before the Jan. 15 meeting of the Portage County Medical So-ciety.—Emily J. Widdecombe, M.D., secy.

SUMMIT

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was guest speak-er at the Jan. 5 meeting of the Summit County Medical Society, at the Nurses' Home, City Hospital, Akron. His subject was, "Specific Differential Diagnosis and Precise Hematologic Therapy".—Bulletin.

TRUMBULL

Officers chosen for 1948 by the Trumbull Coun-ty Medical Society include: Dr. E. G. Kyle, New-ton Falls, pres.; Dr. Densmore Thomas, Niles, pres.-elect; Dr. E. G. Caskey, Mineral Ridge, secy.-treas.; Dr. Harry A. Smith, Bristolville, del-egate; and Dr. S. J. Shapiro, Warren, alternate.—E. G. Caskey, M.D., secy.-treas.

The society held its postgraduate day at Warren on Nov. 19. Visitors were present from Alliance, Akron, Canton, Greentown, Salem, Bar-ber-ton, Youngstown, and Pittsburgh. The pro-gram committee reported contacting the Univer-sity of Virginia for a postgraduate day next Nov. 3.—E. G. Caskey, secy.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

COSHOCTON

Dr. E. J. Booth, Coshocton, was elected presi-dent of the Coshocton County Medical Society

for 1948 with the following other Coshocton phy-sicians elected to other offices: Dr. G. W. Stelzner, pres.-elect; Dr. H. W. Lear, secy.-treas.; Dr. G. A. Foster, delegate; and Dr. F. W. Craig, alternate.—H. W. Lear, M.D., secy.-treas.

HARRISON

The following officers were elected for 1948 by the Harrison County Medical Society: Dr. G. E. Vorhies, Scio, pres.; Dr. Carl F. Goll, Hopedale, pres.-elect; Dr. R. W. Weiser, Jewett, secy.-treas.; Dr. Goll, delegate; and Dr. E. L. Miller, Bowers-ton, alternate.—Richard W. Weiser, M.D., secy.-treas.

TUSCARAWAS

The Tuscarawas County Medical Society had as speaker at the January meeting Dr. Philmour M. A. Bein, staff surgeon at the Mansfield Gen-eral Hospital, who spoke on "The Early Ambu-lation of the Patient".

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

LICKING

New officers of the Licking County Medical Society for 1948 are: Dr. Dale E. Roth, Newark, pres.; Dr. L. H. Miller, Granville, secy.-treas.; Dr. George A. Gressle, Newark, delegate; and Dr. R. S. Manning, Newark, alternate.

MORGAN

Members of the Morgan County Medical So-ciety elected the following officers for 1948: Dr. C. E. Northrup, McConnelsville, pres.; Dr. E. G. Rex, McConnelsville, secy.; Dr. Henry Bockman, Malta, delegate; and Dr. A. A. Coulson, McCon-nelsville, alternate.

MUSKINGUM

Members of the Muskingum County Academy of Medicine had as guest speaker on Jan. 7, Dr. Ralph Sommerfield of Akron who spoke on, "Anaesthesia".—Beatrice T. Hagen, M.D., secy.

Ninth District

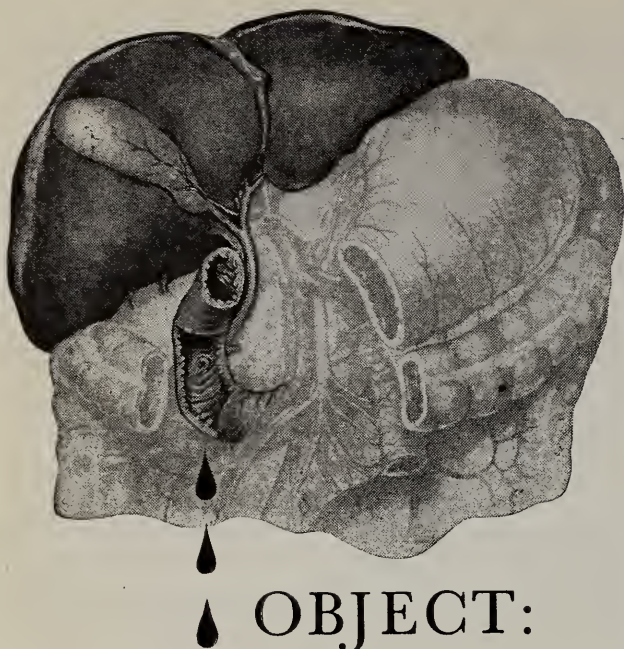
(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

GALLIA

The following officers were elected for 1948 by the Gallia County Medical Society: Dr. C. E. Richards, Gallipolis, pres.; Dr. Homer B. Thomas, Gallipolis, secy.-treas.; and Dr. Francis W. Shane, Gallipolis, delegate.

JACKSON

New officers of the Jackson County Medical Society are: Dr. Brinton J. Allison, Oak Hill, pres.; Dr. G. B. Ackerman, Wellston, pres.-elect; Dr. R. L. Woodyard, Oak Hill, secy.-treas.; Dr.



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.



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John Frazer, Wellston, delegate; and Dr. C. C. Fitzpatrick, Jackson, alternate.

LAWRENCE

Members of the Lawrence County Medical Society elected the following officers, all of Iron-ton, for 1948: Dr. W. Ray Swango, pres.; Dr. Charles H. Gallagher, pres.-elect; Dr. William A. French, secy.-treas.; Dr. W. F. Marting, delegate; and Dr. John A. Dole, alternate.

SCIOTO

Members of the Hempstead Academy of Medicine met at General Hospital, Portsmouth, on Jan. 12 and heard a talk by Dr. George Nelson, Columbus, on, "Coronary Artery Disease".—J. P. McAfee, M.D., secy.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

DELAWARE

Newly elected officers of the Delaware County Medical Society for 1948 are the following Delaware physicians: Dr. W. E. Borden, pres.; Dr. D. S. James, pres.-elect; Dr. F. M. Stratton, secy.-treas.; Dr. B. R. Lauer, delegate; and Dr. G. J. Parker, alternate.

FAYETTE

The following Washington C. H. physicians were elected officers for 1948 of the Fayette County Medical Society: Dr. A. D. Woodmansee, pres.; Dr. Marvin H. Roszmann, vice-pres.; Dr. Joseph M. Herbert, secy.-treas.; Dr. James E. Rose, delegate; and Dr. E. H. McDonald, alternate.

KNOX

Members of the Knox County Medical Society elected the following officers for 1948: Dr. R. S. Lord, Fredericktown, pres.; Dr. John Baube, Mount Vernon, pres.-elect; and Dr. Robert Hoecker, Mount Vernon, secy.-treas.

PICKAWAY

Physicians of Circleville elected as officers of the Pickaway County Medical Society for 1948 are: Dr. D. V. Courtright, pres.; Dr. H. D. Jackson, vice-pres. and alternate; Dr. W. F. Heine, secy.-treas.; and Dr. G. W. Heffner, delegate.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

HOLMES

Holmes County Medical Society officers for 1948 include the following Millersburg physicians: Dr. Luther W. High, pres.; Dr. Owen F. Patterson, secy.-treas.; Dr. Nevin P. Stauffer, delegate; and Dr. Adam J. Earney, alternate.

LORAIN

"Surgical Emergencies", was the subject discussed by Dr. Donald M. Glover, Western Re-

serve Medical School, before the Jan. 13 meeting of the Lorain County Medical Society at the Spring Valley Country Club, Elyria.—L. H. Trufant, M.D., secy.

RICHLAND

Dr. Paul A. Blackstone, Belleville, was elected president of the Richland County Medical Society for 1948 with the following Mansfield physicians elected to other offices: Dr. Robert R. Crawford, vice-pres.; Dr. R. D. Campbell, secy.-treas.; Dr. John S. Hattery, delegate; and Dr. George L. Evans, alternate.

WAYNE

The following Wooster physicians were elected officers for 1948 for the Wayne County Medical Society: Dr. Adrian J. Hartzler, pres.; Dr. William R. Schultz, pres.-elect; Dr. R. C. Paul, secy.-treas.; Dr. F. C. Gaynard, delegate; and Dr. R. N. Wright, alternate.

Woman's Auxiliary News

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

FAYETTE

The Fayette County Medical Society Auxiliary met December 9 in the Colonial Room of the Washington Hotel, Washington, C. H. It was announced that all members have subscribed to the *Woman's Auxiliary Bulletin*. Plans were made to establish a "Loan Cabinet" of emergency hospital supplies available to the public day or night. On December 14, a Christmas party was held at the Washington Hotel.

HARDIN

On November 29, members of the Hardin County Medical Society and their wives met in Kenton for dinner, the first joint meeting since the organization of the Woman's Auxiliary in April. Dr. and Mrs. Harold K. Mouser, of Marion, were out-of-town guests for the evening. Mrs. Mouser, president of the State Auxiliary, spoke of the work being done in the different counties.

LUCAS

On January 20, the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County held its regular meeting in Toledo. Dr. E. L. Burns discussed "The Academy Plan for Early Detection of Uterine Cancer".

MARION

On November 13, the Auxiliary to the Marion Academy of Medicine entertained the members of the Academy at a six o'clock dinner at the Hotel Harding, Marion. Mrs. Richard Morgan, president of the Auxiliary, presented the guest speaker, Dr. Floyd Faust, of Columbus. His subject was "Fit for Freedom". On Saturday, December 13, the Auxiliary met to make ambulance slippers for the hospital. This meeting

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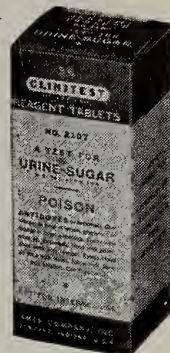
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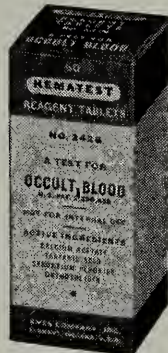
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took the place of the usual Christmas party and gift exchange which the Auxiliary heretofore held at this season.

RICHLAND

At the November 3 meeting of the Woman's Auxiliary to the Richland County Medical Society, 33 members were present and four new members were announced. Fifty per cent of the members are subscribers to the *Woman's Auxiliary Bulletin*. The program was given by Miss Margaret Hunsicker, associate general secretary of the State Nurses' Association.

At the meeting held December 1 at the Woman's Club, Mansfield, 27 members attended and one new member was announced. The names of girls in high school interested in the nursing profession were given, including 24 girls from the senior high in Mansfield, five girls from Madison Township, Richland County. Plans were made to entertain these girls at a tea.

TUSCARAWAS

The Woman's Auxiliary of the Tuscarawas County Medical Association recently enjoyed a covered-dish Christmas party. After a book review, "Home For Christmas", a gift exchange completed the evening.

WASHINGTON

A number of prizes were awarded at the Betsey Mills Club gymnasium November 14, when the Woman's Auxiliary to the Washington County Medical Association entertained with a benefit bridge and style show. The purpose of the event was to raise money for the Marietta Memorial Hospital fund, and more than 300 guests enjoyed the evening's entertainment.

On December 10, a dinner meeting was held at the Betsey Mills Club. Dr. Fritz Marti, head of the philosophy department at Marietta College, told of the customs of the Christmas season in his native Switzerland. He illustrated his talk with pictures of churches, public buildings, the people, their homes, and the countryside. Mrs. Marti, accompanied the group at the piano when Christmas carols were sung.

At a short business meeting which followed, Mrs. George Huston was elected as delegate and Mrs. Ford Eddy as alternate to the state convention.

Cancer Diagnosis Course at Cornell

A course in Cytologic Diagnosis of Cancer will be conducted at the Cornell University Medical College, New York City, March 8 to 20, under the direction of Dr. George N. Papanicolaou. It will include lectures, discussions, demonstration of slides, and study of representative smears from various fluids. The tuition is \$100. Additional information may be obtained by addressing Dr. Papanicolaou at the college, 1300 York Avenue, New York 21.

Buckeye News Notes

Cincinnati—Dr. Albert L. Haas has been re-elected chief of staff of Bethesda Hospital. Other officers include: Dr. Clyde S. Roof, vice-president, and Dr. Edgar B. Snyder, secretary-treasurer.

Cincinnati—Dr. E. H. Schoenling, health commissioner of Hamilton County for the past 18 years, has resigned.

Cincinnati—At the Jan. 5 meeting of the Philadelphia Ophthalmologic Club, Dr. K. W. Ascher, University of Cincinnati College of Medicine, was a guest speaker. He discussed the "Present Status of the Aqueous Veins".

Cleveland—Dr. William E. Bruner celebrated his 82nd birthday recently by working in the Guardian Building where he has had his offices for the past 52 years. Friends in the building arranged a birthday party in his honor.

Clyde—Dr. E. W. Baker, dean of Sandusky County physicians, recently celebrated his 88th birthday.

Columbus—Dr. Thomas D. Santurello, Columbus, has been appointed by Governor Thomas J. Herbert to a three-year term on the State Board of Cosmetology.

Coshocton—The local hospital situation was discussed by Dr. R. E. Hopkins at a meeting of the Kiwanis Club.

Dayton—Staff members of St. Elizabeth Hospital recently presented gold pen and pencil sets to Dr. Sterling H. Ashmun and Dr. Norman C. Hochwalt in recognition of their more than 25 years' outstanding service.

Dayton—Officers of the War Veterans Physicians of Montgomery County include Dr. T. E. Newell, president; Dr. Fred Miller, vice-president; Dr. William H. Gitman, treasurer; and Dr. Richard Sauer, secretary.

Lancaster—Dr. Lloyd L. Kersell is the new health commissioner of Fairfield County, succeeding Dr. W. R. Coleman who retired Jan. 1, after 12 years' service.

McConnellsville—Dr. C. E. Northrup has been re-elected health commissioner of Morgan County.

Madison—Honored by the personnel of the Lake County Health Board at a dinner recently, Dr. J. V. Winans completed 60 years in the practice of medicine in January. He has been president of the board for 27 years.

Mansfield—Dr. Max Brown is the new chief of staff of General Hospital. He succeeds Dr. Lloyd Bonar.

Mansfield—"Cancer" was the topic discussed by Dr. Arthur James, Columbus, at a meeting of the Kiwanis Club.

Marengo—Dr. W. E. DeVol, a former medical missionary to China, spoke on "Men and Mis-

sions" at a meeting in the Alum Creek Friends church.

Montpelier—Dr. Howard J. Luxan was elected one of three directors of the Northwestern Ohio Holstein Club.

Newark—Two delivery tables and obstetrical tables of identical design have been presented to Newark Hospital by Dr. and Mrs. J. W. Barker in commemoration of the doctor's completion of 50 years in the practice of medicine.

Oxford—A practicing physician here for 63 years, Dr. C. O. Munns recently observed his 84th birthday by taking care of his patients as usual.

Portsmouth—Dr. William E. Scaggs is the new president of the Exchange Club.

Sandusky—Dr. Ernst Speyer spoke on "The Atom and the Universe" at a meeting of the Rotary Club.

Steubenville—The importance of immunization in the control of childhood diseases was explained by Dr. J. R. Cohen at a meeting of the Roosevelt School P.T.A.

Toledo—The importance of sex education from early childhood through college was stressed by Dr. Glenn H. Reams at a Toledo Town Meeting.

Troy—"Health Education" was the topic discussed by Dr. Brent A. Welch, Troy and Miami County Health Commissioner, at a meeting of the Rotary Club.

West Milton—Dr. H. R. Pearson has begun his 54th year in the active practice of medicine. He is president of the Citizens National Bank and a former clerk of the Board of Education.

Wooster—"Tuberculosis Control" was the subject discussed by Dr. Joseph B. Stocklen, Cleveland, Controller of Tuberculosis for Cuyahoga County, at a meeting sponsored by the the Wayne County Tuberculosis and Health Association in the Board of Trade rooms.

Youngstown—Dr. Raymond C. McKay, chief of the tuberculosis division of Cleveland City Hospital, spoke on "The Present Status of B.C.G. Vaccine", at a recent meeting of the medical staff of the Mahoning Tuberculosis Sanatorium.

Youngstown—The new medical director of the Mahoning Tuberculosis Sanatorium is Dr. William Newcomer, for the last year assistant medical director of the Moore V. A. Hospital at Swannanoa, N. C., and previously a commander in the Navy Medical Corps.

Xenia—Discontinuance of Espey Hospital has been announced by Dr. Paul D. Espey, who has operated that institution for the past 32 years. Dr. Espey will continue in the practice of medicine.

Zanesville—Dr. Fred W. Phillips gave an illustrated address on his recent trip to Alaska, at a meeting of the Exchange Club.

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Licenses Granted 21 Doctors of Medicine By State Medical Board

Licenses to practice medicine and surgery in Ohio were granted to 21 graduates of schools of medicine who passed the December examinations, according to an announcement from the Ohio State Medical Board, which met January 6 in Columbus.

Dr. Robert H. Hamlin, Columbus, a graduate of the Northwestern University School of Medicine, scored highest in the examinations with a grade of 91.1 per cent. Second was Dr. Elmer C. Rost, Jr., Toledo, a graduate of Loyola University, 89 per cent; third, Dr. Mary A. Thomas, Cleveland, Hahnemann Medical College, 88.7 per cent; and fourth, Dr. Sidney Larson, Canton, University of Manitoba, 88.4 per cent.

Ten graduates of osteopathic schools, who complied with the requirements, were successful, and will receive certificates to practice osteopathic medicine and surgery. In addition, certificates to practice osteopathic medicine and surgery, were granted three osteopaths, previously licensed to practice osteopathy and surgery, on the basis of successful completion of additional examinations.

In the limited branches, certificates were awarded to four chiropractors, 16 mechanotherapists, five cosmetic therapists, two chiropodists, and 34 masseurs.

The following doctors of medicine were granted licenses:

Harold J. Delchamps, Jr., Dayton, Cornell University; George P. Daurelle, Jr., Lansing, Mich.; William D. J. Donaldy, Cleveland; Maynard A. Pike, Willoughby; Robert K. Rank, E. Cleveland; Edward P. Reese, Lansing, Mich.; Mary A. Howe Thomas, E. Cleveland; Royal Monroe Thomas, E. Cleveland; Walter B. J. Schuyler, E. Cleveland, all of Hahnemann Medical College.

Arthur J. Blanchard and Elmer Charles Rost, Jr., Loyola University; Robert H. Hamlin, Columbus, and Elizabeth Cowgill Innis, Jackson, Northwestern University.

Arthur O. Hoffman, Cambridge, St. Louis University; Roger C. Troup, Akron, Southwestern Medical College; Alden S. Thompson, Ann Arbor, Mich., Temple University; David M. Spencer, Troy, University of Cincinnati; Robert T. Maurer, New Philadelphia, University of Rochester; Ilka W. Adler, Chagrin Falls, University of Vienna, Austria; Hodge M. Eagleson, Jr., Pittsburgh, Univ. of Pittsburgh; and Sidney Larson, Canton, Univ. of Manitoba.

Compulsory immunization against diphtheria and smallpox will be required for children entering Columbus public schools effective February 5 as the result of action by the Columbus Board of Education.

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Licensed Through Endorsement By State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

August 12, 1947—Frazier D. Alexander, Columbus, Meharry; Robert L. Anderson, Columbus, Univ. of Kansas; Louis Belinson, Columbus, Rush Medical College; Louis Berman, Columbus, Univ. of Berne; Otto Billig, Cleveland, Univ. of Vienna; Malcolm Block, Dayton, Univ. of Michigan; Buford H. Burch, Columbus, Washington Univ.; Richard W. Burger, Lorain, Univ. of Pittsburgh; Robert G. Caley, Lynchburg, Indiana Univ.; A. L. Chatman, Cleveland, Meharry; Jay B. Cohn, Youngstown, Yale; Stanford J. Coleman, Middletown, Meharry; Robert F. Conry, Cleveland, Univ. of Nebraska; Donald W. Crittenden, Andover, Jefferson.

Bernard C. Dienger, Cincinnati, Creighton; F. Paul Duffy, Cincinnati, Univ. of Cincinnati; Alfons P. Falkenstein, Salem, Univ. of Bonn; John R. Frantz, Worthington, College Medical Evangelists; William J. Gleckler, Cleveland, Univ. of Pennsylvania; Robert S. A. Green, Cincinnati, Univ. of Cincinnati; John J. Head, Canton, Yale; Joseph W. Kolp, North Canton, St. Louis; Harry J. Konerman, Cincinnati, Loyola; Earl J. Levine, Wellston, Univ. of Virginia; Matthew Levine, Cincinnati, Long Island; Felix B. Martin, Cincinnati, Meharry; Norman G. Mathieson, Toledo, Univ. of Pittsburgh; Brown McDonald, Jr., Racine, Jefferson; Carroll D. Miller, Fremont, Wayne.

Stephen K. Molnar, Columbus, Wayne; Harold E. Mulier, Barberton, Univ. of Pittsburgh; Hugh B. Munson, Youngstown, Geo. Washington Univ.; Richard D. Murray, Youngstown, Georgetown Univ.; Herman Nussbaum, Columbus, Jefferson; Vincent J. Parlante, Bellevue, Univ. of Buffalo; Marshall J. Pierson, Akron, Temple; Howard E. Sanders, Springfield, Johns Hopkins; Edward A. Sawan, Akron, Georgetown Univ.; Edward F. Scanlon, Steubenville, Columbia Univ.; Frederic N. Silverman, Cincinnati, Syracuse; Harold W. Spies, Alliance, Geo. Washington Univ.; Martin R. D. Sutler, Jr., Cleveland, Univ. of Michigan; Richard C. Taylor, Bay Village, Boston Univ.

Abraham Unger, Columbus, Anderson College; Leslie D. Urban, Ironton, Loyola; John S. Watson, Cincinnati, Univ. of Cincinnati; Eugene J. Weber, Cleveland, Univ. of Rochester; Richard S. Wilson, Cleveland, Univ. of Rochester; Robert E. Wise, Cleveland, Univ. of Maryland; Charles E. Work, Cincinnati, Vanderbilt.

October 14, 1947—Laszlo S. Arany, Youngstown, Royal Elizabeth Univ.; Erwin Asriel, Akron, Univ. of Vienna; Geoffrey W. Bennett,

W. H. MILLER, M. D.

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Wooster, Univ. of Iowa; Edward F. Buyniski, Dayton, Tufts Medical College; Lionel A. Canaan, Hicksville, Royal College; Clarke T. Case, Columbus, Harvard; Thomas N. Davis, III, Massillon, Univ. of Virginia; William R. Dorsey, Columbus, McGill Univ.; Henry F. Drygas, Oberlin, Univ. of Michigan; Henry C. Exell, Jr., Columbus, Vanderbilt; Charles D. Feuss, Jr., Cincinnati, Vanderbilt; Donald G. Henderson, Canton, McGill Univ.; John R. Higerd, Ashtabula, Hahnemann; Rollin C. Hudson, Kent, Univ. of Maryland.

Edwin R. Irgens, Gallipolis, Univ. of Pennsylvania; Edwin P. Jordan, Cleveland Heights, Rush Medical College; Thomas A. Koons, Marietta, Indiana Univ.; Leonard W. Kuehnle, Cincinnati, Marquette; Dolor J. Lauer, Cincinnati, Univ. of Minnesota; Edgerton R. Laughlin, Gallipolis, Univ. of Toronto; Mary B. Laughlin, Gallipolis, Univ. of Toronto; Franz Lengh, Columbus, Univ. of Vienna; Paul G. Lukats, Barberton, Univ. of Maryland; Bruce C. Martin, Columbus, Washington Univ.; Luther C. Martin, Cincinnati, Med. College of South Carolina; Frederic G. Maurer, Jr., Dayton, Marquette; Herman P. McCrimmon, Toledo, Univ. of Oklahoma.

Ward C. Meyers, Columbus, Northwestern; Charles F. Moll, Jr., Toledo, St. Louis; Axel R. Nelson, Columbus, Univ. of Pennsylvania; Edward J. O'Malley, Lakewood, St. Louis; D. Donald Pellicciari, Columbus, Univ. of New York; George S. Rigas, Weirton, Univ. of Athens; Jacques Robbins, West Alexandria, Univ. of Paris; James Rudel, Columbus, Charles Univ.; Amedo B. Saeli, Toledo, St. Louis; Joseph Schaefer, Akron, Univ. of Minnesota; Richard P. Schmidt, Akron, Univ. of Louisville; John L. Shultz, Hartwell, Univ. of Buffalo; Joseph L. Svehla, Cleveland, St. Louis; Florence Takacy, Shaker Heights, Woman's Medical College; Iwao Uyeda, Cleveland Tulane; Edward C. Weiford, Cleveland, Univ. of Kansas; William M. Wiley, Napoleon, Indiana Univ.

Scholarships to Chest Course Offered by TB Association

Three scholarships are being offered in Ohio to a postgraduate course in thoracic diseases sponsored by the American Trudeau Society in cooperation with the Detroit Department of Health at Wayne University College of Medicine, Detroit, Mich., March 22-26.

The Ohio Tuberculosis and Health Association, 1517 Neil Ave., Columbus, is offering three \$100 scholarships to Ohio physicians. Deadline for receipt of applications is Feb. 9. Application blanks may be secured from the association or from county tuberculosis societies. Dr. John H. Skavlem of Cincinnati is chairman of the committee on qualification.

Clergyman Named to Hospital Council

Appointment of Monsignor Robert A. Maher, Toledo, as a member of the Hospital Advisory Council of the State Health Department, was announced early in January by Dr. John D. Porterfield, director. He replaces A. David Bouterse, Columbus, who resigned. Mr. Bouterse said that his duties as executive secretary of the Ohio Welfare Council prevented his remaining on the council.

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Clarifies Law on Hospitalization Furnished Under Poor Relief

Clarification of language contained in Amended Senate Bill No. 178, passed during the recent regular session of the General Assembly and regarding the inclusion of "hospitalization" with other commodities and services provided at public expense under the poor relief law, is contained in Opinion No. 2543, which was rendered by Attorney General Hugh S. Jenkins on December 30.

The ruling was in answer to a communication from Charles L. Sherwood, director of the Ohio Department of Public Welfare. Director Sherwood asked "to what extent will the county poor relief authority be responsible for hospital care, and what will be the responsibility of the township trustees in view of the language of the bill?"

The Attorney General's answer indicated that it is the duty of the local poor relief area to furnish hospitalization to the extent of not more than three months in any one calendar year; and that the furnishing of such care in excess of three months is the responsibility of the township trustees.

A second question regarded the responsibility of the local poor relief authority to provide medical care in those cases for which the township trustees might undertake the furnishing of hospital care.

In reply the Attorney General cited Opinion No. 2648, of 1940, which fixes the responsibility of furnishing medical care with the local poor relief authority. He added that since there has been no change in the provisions for "medical care" under the relief laws since the 1940 opinion, it is therefore the responsibility of the local relief authority to provide the medical care in cases for which the township trustees furnish the hospitalization.

Dr. Forman Re-elected to Allergy Board, Speaks on Conservation

Clyde Williams, director of Batelle Institute of Columbus, recently was elected president of the American Allergy Foundation, to succeed Dr. Jonathan Forman, editor of *The Ohio State Medical Journal*. Dr. Forman was re-elected to another three-year term as a member of the Board of Directors.

Dr. Forman, representing the Friends of the Land, and Hart F. Page, of the Ohio State Medical Association, attended a dinner meeting of the Ohio State Department of Agriculture in Columbus, January 13.

"What Conservation Can Do for the Health of the People of Ohio", was the topic of a talk by Dr. Forman at the annual meeting of the district supervisors of the Ohio Soil Conservation Service in Columbus, January 16.

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ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting Feb. 16, March 15, April 12.
Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting March 1, March 29, April 26.

Surgical Anatomy & Clinical Surgery, two weeks, starting February 16, March 15, April 12.

Surgery of Colon & Rectum, one week, starting March 8, April 26.

Surgical Pathology every two weeks.

FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting June 7.

GYNECOLOGY—Intensive Course, two weeks, starting February 23, March 29.

Personal Course in Vaginal Surgery starting March 22, April 19.

OSTETRICS—Intensive Course, two weeks, starting March 15, April 12.

MEDICINE—Intensive Course, two weeks, starting April 26.

Personal Course in Gastroscopy, two weeks, starting March 29, April 19.

Electrocardiography & Heart Disease, four weeks, starting February 16, May 3.

CYSTOSCOPY—Ten Day Course starting March 1, March 15, March 29.

DERMATOLOGY—Formal Course, two weeks, starting April 26.

Clinical Course every two weeks.

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In the event of the death of such workman as a result of an injury under such circumstances, his dependents would be entitled to benefits similarly computed.

Navy Commissions Are Open

Public Law 365 makes it possible now for civilian doctors of medicine to become commissioned officers in the regular Navy, provided they meet the professional and physical qualifications. The law does away with the age limit of 32, and permits doctors in civilian practice to be commissioned with ranks up to and including captain.

Endocrinology Course Scheduled

The postgraduate committee of The Association for the Study of Internal Secretions, will sponsor a course of lectures and demonstrations in Clinical Endocrinology to be held at the Biltmore Hotel, Los Angeles, Feb. 23-28. Among the speakers will be Dr. E. Perry McCullagh, Cleveland.

Essay Award Offered

The eighth annual essay contest of the Mississippi Valley Medical Society, 209-224 W. C. U. Bldg., Quincy, Ill., will be held in 1948. The society will offer a cash prize of \$100, a gold medal, and a certificate of award for the best unpub-

lished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine.

Chest Course Scheduled

The American College of Chest Physicians, Pennsylvania Chapter, and the Laennec Society of Philadelphia are sponsoring a postgraduate course in diseases of the chest to be held during the week of March 15-20 at the Warwick Hotel, Philadelphia, Pa.

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Research on Tissue Changes Planned

The recently formed Pharmaceutical-Medical Research Foundation, according to an editorial in the January 3 issue of *The Journal of the American Medical Association*, plans to make extensive studies relating to the chemical and physical changes that occur in tissues and to the physiology of the body—particularly concerning substances taken into the body and their ultimate fate.

Health Honors Bestowed

Awards of honor for distinguished service to the cause of public health during 1947 were made to Dr. William H. Muhlberg, president of the Cincinnati Board of Health, and Bleecker Marquette, executive secretary of the Public Health Federation of Cincinnati, by the committee on awards of the Public Health Federation.

Supplement Is Available

The American Pharmaceutical Association announces the publication of the first supplement to the National Formulary VIII. Users of the formulary may obtain the supplement by writing to the American Pharmaceutical Association, 2215 Constitution Ave., N. W., Washington 7, D. C.

Alcoholism Meet Scheduled

The First Industrial Conference on Alcoholism, originally scheduled to be held on March 15, will now be held on Tuesday, March 23, at the Morrison Hotel, Chicago. Designed to bring to the attention of industry leaders throughout the country facts pertaining to the problem of alcoholic employees and to discuss ways and means of overcoming the problem, the conference is sponsored by the Chicago Committee on Alcoholism. Dr. Anton J. Carlson, University of Chicago, is chairman of the conference, and James H. Oughton, Jr., of the Keeley Institute, Dwight, Ill., co-chairman.

Dr. Fishbein To Give Course

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, will give an instructional course in medical writing at the annual meeting of the Mississippi Valley Medical Editors' Association, to be held at Springfield, Ill., next Sept. 29, during the annual meeting (Sept. 29, 30, Oct. 1) of the Mississippi Valley Medical Society in that city. Details of the meeting may be obtained by writing the secretary, Dr. Harold Swanberg, 209-224 W. C. U. Bldg., Quincy, Ill.

Portsmouth—Dr. Dow Allard, chief of staff of Mercy Hospital, was the principal speaker at the Thanksgiving dinner meeting of the Mercy Hospital guild.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

WANTED: Public Health Commissioner in Tuscarawas County, New Philadelphia, Ohio. Must have degree in public health, to serve in county with a population of 40,000; the salary, \$6,600, plus traveling expenses. Write Office of Tuscarawas County Board of Health, New Philadelphia, Ohio.

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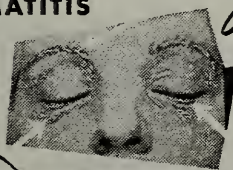
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WANTED: Young or Middle-aged physician for large rural community at New Madison, O. Contact O. P. Kimmel, M.D., New Madison, Ohio.

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The Physician's Bookshelf

The Living Soil, by E. B. Balfour, (12s 6d. *Faber and Faber, Ltd., 24 Russell Square, London, England*) presents the evidence of the importance to human health of soil vitality, with special reference to postwar planning. Lady Eve Balfour has admirably succeeded in writing for both the specialist and the layman. The author after a preliminary survey of the nature of soil, soil erosion, and a discussion of the Law of Retra, presents the evidence. In the chapter on the "Medical Evidence", she recites much of the same data that one sees in so many of her publisher's books, viz.: The recital of "the medical testament" of the committee of the physicians of the County of Cheshire; the work of Sir Robert McCarrison; the observations of G. T. Wrench both in England and among the Hunzas in India; Sir John Orr's experiments; the story of the McMillan Nursery School; and the Papworth settlement of Sir Pendrell Varriest-Jones; as well as the experience with housing project of Mount Pleasant. Lady Balfour then goes on from discussing the importance of humans to point out the direct evidence on Soil Ecology, the circumstantial evidence of dozens of experiences throughout the world. Then follows the use of the knowledge to cure and prevent disease among plants, animals, and humans. Readers of *The Journal* should read Lady Balfour's supremely important as well as biologically fascinating book to broaden their own concept of primary causes of diseases—inclement weather, bad climate, poor food, inadequate protection because of the lack of clothing and shelter, overcrowding, and poor inheritance.

Handbook of Psychiatry, by Louis J. Karnosh, M.D., and Edward M. Zucker, M.D., (*C. V. Mosby Company, St. Louis, Missouri*) presents the basic principles of psychiatry in a very simple form. The authors have faithfully illuminated the necessary fundamental information. For those of us not trained in the specialty, it is a useful guide and as such should be widely read.

Nutrition in Industry, (\$1.50. *International Labour Office, Washington, D. C.*) is composed of three parts, e.g., "Nutrition in Canadian Industry", by Lionel Bradley Peet, M. D., "The Wartime Food and Nutrition Programme for Industrial Workers in the United States", by Robert S. Goodhart; and "Industrial Canteens in Great Britain", by David H. Bulloch, M. D.

Laboratory Manual of Microbiology for Nurses, by Elizabeth S. Gill, R.N., and James T. Culbertson, Ph.D., (\$1.50. *G. P. Putnam's Sons, New York City*) emphasizes that from this science nurses learn how to prevent the spread of infec-

tions. Hence the importance of instruction in the handling of pathogenic bacteria.

Synopsis of Obstetrics, by Jennings C. Litzenberg, M.D., (\$5.50. Third Edition. *C. V. Mosby Company, St. Louis, Missouri*) brings all of the good of the previous editions and adds now the trustworthy tests for the diagnosis of pregnancy in the laboratory; relief from the pains of labor; diabetes in pregnancy; puerperal infection and sulfonamides and penicillin; and the relation of the Rh factor and pregnancy.

Theories on Mutations and the Formation of Some Benign and Malignant Tumors, by Manuel D. Nornedo, M.D., (\$2.00. *William-Frederick Press, New York City*) are proposed in this monograph in the hope that they attract the attention of others interested in cancer, especially research workers. A stimulating proposal to those interested in the genetic or virus phases of the problem.

Communicable Diseases, by Franklin H. Top, M.D., (\$8.50. Second Edition. *C. V. Mosby Company, St. Louis, Missouri*) presents fourteen new chapters. The beautiful colored illustrations add much to the book. The reception of the first edition bespeaks a hearty one for this edition.

Awake and Away, by L. W. Irwin, Ph.D., W. W. Tuttle, Ph.D., and C. DeKolver, B.S., (\$1.25. *Lyons and Carnahan, Chicago*) is a beautifully illustrated text teaching the simpler rules of living. Most of us busy physicians do not realize what a good job the text writers and illustrators of health books for our schools are doing.

Love and Happiness, by Nancy Jacobs, (\$5.00. *Mosher Press, Boston, Massachusetts*) is a little book which attempts to tell you who you really are, and to give you exact methods to awaken you to realization of what you can do for yourself.

Fundamentals of Immunology, by William C. Boyd, Ph. D., (\$6.00. Second Edition. *Interscience Publishers, Inc., New York City and London*) has not been changed in its original concept of presenting the basic principles of the science. It is one of those books which those of us who have been out of school since the development of clinical allergy and a clearer understanding of the specificity of serological reaction, will do well to read.

Dental Caries, by Bernhard Gottlieb, M. D., (\$10.00. *Lea & Febiger, Philadelphia*) emphasizes this condition as an extreme in special pathology and based upon the peculiar anatomy of the part.

Sun, Soil, and Medicine

SHORTLY after the appeasement at Munich, with Britain rushing frantically on to war, a committee of physicians of the County Palatine of Cheshire, appalled by the prevalence of disease among those who were examined for military service, issued a statement of their opinion of what ought to be done about health. This committee represented the 600 "panel" sickness-insurance doctors in a county of mixed agriculture and industry, a county more famous perhaps for its cheese. These pioneers delivered on March 22, 1939, their appraisal of their efforts to "prevent and cure sickness" in their now famous *Medical Testament*.

These doctors were under the influence of one of the great unorthodox agriculturists of all time—Sir Albert Howard. Before this man became convinced that the way to keep a soil in full fertility was to use composting, he had come to be recognized as one of the leading agricultural scientists in the British Empire. Graduating from Cambridge with honors in 1898, he served successfully as a research mycologist studying the diseases of sugar cane in the West Indies, and as a botanist in the South-eastern Agricultural College at Wye, England. For nearly twenty years, he was the Imperial Economic Botanist to the Government of India, and then for seven years he served as Director of the Institute of Plant Industry at Jadore and Agricultural Advisor to States in Central India and Rajpuna.

SOIL-HEALTH RELATIONSHIP

While working in India, Howard had been impressed by the work of Sir Robert McCarrison, a physician. Both men became convinced of the intimate relationship between the soil upon which the food was grown and the health of the people who ate that food.

In 1940, Sir Albert published one of the most significant books of our times, his *Agricultural Testament* (Oxford University Press). Shortly thereafter, he found himself the leader of a world-wide movement with a flourishing press in England, New Zealand, and the United States, and a rapidly growing number of followers among practical farmers and amateur gardeners.

SOIL MANAGEMENT PROGRAM

We need not get into this controversy between those who use and those who condemn commercial chemicals as fertilizers. The point is that in this and his subsequent books, Sir Albert Howard has given a convincing account of an effort to improve plant and animal health through a soil-management program that did not fit into the current ideas.

When Howard is writing of the importance of mycology, he writes as an authority. When he writes of the importance of humus, all are agreed. When he writes of the use of composts and the consequent health of plants, even his severest critics do not question the accuracy of his observations, for all recognize the inherent honesty of the man. When he writes of the health of animals and people in relation to the soil, he opens himself to more lively discussion. First, he did not himself have the necessary medical background to evaluate these relationships and, secondly, he offers no particular results that are reliable. His evidence, almost all of the testimonial variety, is quite convincingly presented. Consequently, he is accused of entering the realm of specialization with, in some instances, unfortunate results. Hence the Testament of Sir Albert's is not to be taken as a part of the Scriptures, but rather as a challenge to every scientific worker in the field of agriculture and human nutrition.

PREVENTIVE MEASURES

Nevertheless, Sir Albert Howard is a temperate but robust controversialist. He, himself, had been greatly impressed with the work of Sir Robert McCarrison. Dr. McCarrison, himself a physician, had a good many clinical and experimental observations to support Howard's contentions. Howard and McCarrison were both called in to advise this committee of physicians. It was only to be expected, therefore, that when the doctors of County Palatine of Cheshire came under the influence of these two men that they should come to realize that, though their twenty-five years of effort and cure of sickness may have been commendable, little had been done to prevent sickness. They came to realize as a result of all this that "Our daily work brings us repeatedly to the same point: 'This illness results from a lifetime of wrong nutrition.'"

This situation prevailed wherever they turned. They saw anemic mothers and sickly infants, bad teeth, rickets, and constipation. Sir Albert had been preaching the practice of "creative medicine" by which people were to be taught to keep their health instead of how to prevent or cure sickness. To this the Cheshire physicians subscribed, but no such campaign could succeed while farmers and townspeople alike ate all of their white bread, tinned salmon, and dried milk. It was to these things that these pioneering physicians testified, hence—*The Medical Testament* in the fashion of Sir Albert's *Agricultural Testament*.

These doctors then began to improve the diets of the whole countryside and to reconstruct the

whole food economy and food culture of the villagers they served, all the way from the kitchen to the soil on which the food was grown.

If any one man may be said to have been the prime mover of the Cheshire doctors' now historic manifesto, it was Lionel James Picton, O.B.E., who later wrote out his own ideas in a document of uncommon interest. In this volume (*Thought on Feeding, 12 s. 6 d. Net, Faber and Faber, Ltd., 24 Russell Square, London*), Dr. Picton recites the observations and experiences of a long professional life by one who as a young man had been impressed with the importance of food to man and the defective quality of the food upon which he usually feeds.

Dr. Picton belongs to that group of pioneer nutritionists who believe that what matters ultimately the most is the way that our food is grown, whether eaten directly by us or by the animals whose flesh we eat.

EAT WELL TO LIVE WELL

There never was a time in the history of man when the importance of food was greater or more widely recognized. We must eat to live. But the point that Dr. Picton emphasizes is that we must eat well to live well. If our food is defective so shall our bodies become defective. Not the quantity, nor even the variety of our food matters, in comparison with its quality. For most of us Americans, we could do better with less calories and by the same token more than two thirds of our people are in urgent need of foodstuffs of better quality. It is therefore ever so much wiser to change the food habits of our people than to provide them with medical, dental, and hospital care at the taxpayer's expense.

In fact, these Cheshire physicians were constantly running into government regulations that were against the interest of personal health for their people.

They did proceed to teach expectant mothers to eat a simple but effectively adequate diet by which they abolished for the most part maternal morbidity and mortality as well as infant morbidity and mortality. Our rural sociologists who are urging more medical care for farmers' wives ought to take a lesson from the herdsmen who have known for a long time that healthy calves come from well-nourished mothers on an adequate diet. These physicians in Britain recognized as do all too few of our reformers that the dental problem can only be solved by giving the newborn infant teeth of a superior quality through feeding the expectant mother the right foods properly prepared. In selecting such foods, Dr. Picton and his associates insist that they should come from soils of the highest fertility.

They also recognize that a child's diet of natural foods gathered in as fresh a state as possible and not spoiled in their preparation will make the child's teeth last throughout a long life and will give a surprisingly high degree of immunity to the common diseases.

OVER-REFINED FOODS

In looking back over their practices, these physicians saw that most of their chronically-ill were instances of malnutrition, the result of deficient diets. They agree with what we have been preaching up and down this country, that for the most part the so-called degenerative diseases represent a "carbonization" of the human motor resulting from the dumping of the products of incomplete combustion. Thus does the over-refinement of foods and the emphasis upon white flour, sugar, and embalmed meat destroy our culture.

England today stands at the crossroad with all evidence suggesting that British culture is decadent and that as an empire she is through. The adoption of socialism—always a pauper's philosophy—is enough evidence for most of us physicians but the declining birth rate ought to convince everyone.

"England is approaching the ratio of one, only one, under 20 years old to one over 60. In 1839, there were six. Audacity and attack, vision and adventure, endurance till achievement—it is to the young of our race that we look for these. But they are few and growing fewer. Instead we are becoming increasingly a country of elderly back numbers."

We of America should take this lesson to heart. Our birth rate, too, has declined steadily with the advent of machines as we have refined, embalmed, and preserved our foods so that we could keep them on the increasingly small pantry of our city apartment. We are urgently in need of fresh, complete food with a normal content of vitamin A and vitamin E for reproductive purposes if not for the use of Geriatricians.

—JONATHAN FORMAN, M. D.

Health for Young Americans, by W. E. Burkard, Ph. D., R. L. Chambers, Ph. D., and Frederick W. Maroney, M. D., (\$1.00. *Lyons and Carnahan, Chicago*) preaches to school children that it is possible to keep one's health and thus enjoy a more abundant life. More physicians ought to look into the health books of our schools.

I. G. Farben, by Richard Sasuly, (\$3.00. *Boni & Gaer, New York City*) is of great current interest for it is a report to the public of the investigation of the wreck of the industry to identify its war crimes. It is a by-product of the war and a most interesting one.

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New Anticonvulsant Drugs in the Treatment of Epilepsy

HOWARD D. FABING, M.D., and J. ROBERT HAWKINS, M.D.

THE discovery of sodium diphenyl hydantoin (dilantin) by Merritt and Putnam¹ in 1937 ushered in a new era in the medical treatment of epilepsy. It was found that this drug had a far more successful anticonvulsant effect than the drugs such as bromides and phenobarbital which formerly had been employed in the treatment of convulsive disorders. It soon became apparent, however, that the drug had therapeutic limitations. These may be listed as follows: (1) The drug caused a skin rash in an appreciable number of cases; (2) it produced toxic manifestations of diplopia and ataxia in others; and, (3) it caused hypertrophic gingivitis of troublesome degree in some cases. In some of the instances these toxic manifestations occurred without control of the seizures. In other cases, even though the seizures were controlled, toxic manifestations were of such magnitude that the drug could not be used. Therefore, although sodium diphenyl hydantoin (dilantin) has proved to be a highly successful therapeutic agent, the occasional case in which it cannot be employed has prompted the search for new compounds.

Merritt and Putnam have studied the anticonvulsant properties of more than 700 compounds in the laboratory² and have found that few of them are equal to sodium diphenyl hydantoin (dilantin) in anticonvulsant effect, and that many cannot be used clinically because of severe toxic side reactions. A few compounds, however, have shown promise.

¹Read before the Section on Nervous and Mental Diseases at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947.

The Authors

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● Dr. Hawkins, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Medicine, 1938; member, American Psychiatric Association; staff member, Christ, Bethesda, Children's, and Cincinnati General Hospitals; instructor, department of psychiatry, University of Cincinnati College of Medicine.

This report deals with two hydantoin derivatives of good anticonvulsant value and low toxicity. The first compound is sodium diphenylene hydantoin.

SODIUM DIPHENYLENE HYDANTOIN

Acute and chronic toxicity studies on animals³ have demonstrated that this drug can be tolerated in huge quantities without producing death, and that no significant pathological changes are noted after ingestion over long periods of time. In electrically induced convulsions in cats it was found that its anticonvulsant effect was approximately one half that of sodium diphenyl hydantoin (dilantin).

Clinical studies on this drug were begun in March, 1941, and continued until March, 1946.

Effective dosage varied between 0.66 gms. (10 grains) and 3.00 gms. (45 grains). Control of convulsions could seldom be obtained with less than 1.5 gms. (20 grains) per day. The optimum anticonvulsant level was found to be 1.65 to 2.00 gms. (25 to 30 grains) in the usual adult.

Sodium diphenylene hydantoin was found to be efficacious⁴ in 60 of 72 patients (80 per cent). The majority of these patients were clinical failures with sodium diphenyl hydantoin (dilantin). In 12 cases (20 per cent) the drug had to be abandoned for the following reasons: (a) persistent skin rash in nine cases; (b) failure as an anticonvulsant in three cases.

The study produced some interesting findings. The first was that although the morbilliform skin rash produced by sodium diphenyl hydantoin (dilantin) and sodium diphenylene hydantoin were similar morphologically, they were specific for the two drugs. In other words, it was found that some patients developed a skin rash from sodium diphenyl hydantoin (dilantin) but not from sodium diphenylene hydantoin, and vice versa. Secondly, it was found, as in the case of sodium diphenyl hydantoin (dilantin) that mild skin rash often could be overcome by continuation of the drug, but that in other cases its continued use increased the intensity of the rash, necessitating the abandonment of the drug. Thirdly, it was found that the drug never produced the "cerebelloid" symptoms of nystagmus, diplopia or ataxia. Fourthly, the troublesome complications of gum hypertrophy did not occur with sodium diphenylene hydantoin and when this drug was substituted for sodium diphenyl hydantoin (dilantin) in such cases the gums returned to normal. Fifthly, it was found that sodium diphenyl hydantoin (dilantin) and sodium diphenylene hydantoin could be used as synergists in the control of seizures. Sixthly, sodium diphenylene hydantoin proved efficacious in control of grand mal seizures, psychomotor seizures and combined grand mal and petit mal seizures, but did not appear to be efficacious in pyknolepsy (petit mal epilepsy).

At the present time sodium diphenylene hydantoin is not available, but it is our hope and expectation that in the next few months a limited quantity will be produced for further clinical trial.

METHYL-PHENYL-ETHYL HYDANTOIN (MESANTOIN)

Another drug of the hydantoin series which has proved to be of value is methyl-phenyl-ethyl-hydantoin (mesantoin).

Acute and chronic toxicity experiments on animals have demonstrated that this drug has a low toxicity and does not produce tissue changes after ingestion over long periods of time.⁵ We have been studying this drug for the past four

months and have followed 11 patients. Clinical studies on this drug have been made by several other investigators.⁶ The average dosage of methyl-phenyl-ethyl hydantoin (mesantoin) for adults is from 0.2 to 0.6 gms. In some instances 0.8 gms. is required. It is seldom that the drug is efficacious in doses less than 0.4 gms.

Toxic manifestations are skin rash and drowsiness. The drug does not produce hypertrophic gingivitis or "cerebelloid" signs of diplopia, nystagmus or ataxia as in the case of sodium diphenyl hydantoin (dilantin). The rash is generalized and morbilliform and is specific for the compound. In some instances it is possible to continue the use of the drug if the rash is mild, but in other cases the rash increases and necessitates the abandonment of the drug. Drowsiness is a frequent symptom occurring in approximately one half our cases. We have found, however, that our patients overcome this drowsiness in two to four weeks even though the drug is continued. On occasion it is necessary to reduce the dosage temporarily while drowsiness is severe.

We have been favorably impressed with this drug during our short experience with it. Our 11 patients varied in age from 17 to 45 years, and all were sodium diphenyl hydantoin (dilantin) failures, both when this latter drug had been used singly or in combination with barbiturates. In our series the effective anticonvulsant dose has varied between 0.3 gms. and 0.8 gms. We have encountered no skin rashes in this small series, but have noted drowsiness in approximately one half the cases. Methods of combatting this reaction are discussed below.

Methyl-phenyl-ethyl hydantoin (mesantoin) is now available for general use in 0.1 gm. tablets.

TECHNICAL CONSIDERATIONS

Except when confronted with a case of isolated petit mal epilepsy or pyknolepsy, it is our opinion that sodium diphenyl hydantoin (dilantin) is the drug of choice and should be given first trial. If it becomes necessary to abandon it because of its ineffectiveness or because of its toxic reactions, extreme caution must be used in switching the patient over to another of these drugs of the hydantoin series. Sudden withdrawal of sodium diphenyl hydantoin (dilantin) and replacement by either sodium diphenylene hydantoin or methyl-phenyl-ethyl hydantoin (mesantoin) may lead to acute psychotic confusion or to a serious increase in seizures.

It is well to make the replacement slowly over the period of a month or more. If the patient is hospitalized it is possible to make the transfer more quickly. In office practice, however, it is our suggestion that sodium diphenyl hydantoin (dilantin) be reduced at the rate of one capsule (0.1 gm.) per day and replaced by

one tablet of methyl-phenyl-ethyl hydantoin (mesantoin) (0.1 gm.) per day for a period of one week. During the second week sodium diphenyl hydantoin (dilantin) may be reduced by two capsules (0.2 gms.) and replaced by methyl-phenyl-ethyl hydantoin (mesantoin) two tablets (0.2 gms.) per day. In this fashion the switchover often can be made smoothly over a period of weeks. If rash develops, it is well to avoid increasing methyl-phenyl-ethyl hydantoin (mesantoin) or, if necessary, to reduce the dosage as much as 50 per cent until it disappears. If rash is persistent and serious the drug must be abandoned. Likewise we have found that it is advisable to replace one capsule of sodium diphenyl hydantoin (dilantin) by one tablet of sodium diphenylene hydantoin (0.32 gms.) per day in weekly steps and to observe the same consideration in regard to the rash. In the case of methyl-phenyl-ethyl hydantoin (mesantoin) drowsiness may occur at any time during the switchover. In some instances of severe drowsiness it is necessary to wait from two to four weeks before augmenting the dose. In other cases of severe troublesome drowsiness it has been suggested that the dosage of methyl-phenyl-ethyl hydantoin (mesantoin) be advanced by one half tablet per week. By the use of these careful techniques during the transfer period, the side effect of drowsiness with methyl-phenyl-ethyl hydantoin (mesantoin) can be conquered.

It has been our experience that these drugs do not work synergistically with tridione. This latter drug in our experience is efficacious only in some cases of isolated pyknolepsy (petit mal epilepsy) and has no place in the therapy of grand mal or psychomotor attacks.

COMMENT

When one considers that there are 600,000 known epileptics in the United States it becomes apparent that no single drug may be expected to be of value in every case. There is too much individual variation and idiosyncrasy in human pharmacology to allow this. As a consequence, these new drugs come as a welcome addition to the armamentarium of the clinician. It is our belief that other compounds of this series will be discovered in the future and that the epileptic patient will be more nearly assured of clinical benefit when a wide variety of effective anticonvulsants is made available to his physician. It is our belief that sodium diphenylene hydantoin and methyl-phenyl-ethyl hydantoin (mesantoin) are the first of such compounds.

CONCLUSIONS

1. Two new anticonvulsant drugs of the hydantoin series are discussed.
2. The first is sodium diphenylene hydantoin

which has been proved effective in 80 per cent of cases. Skin rash is the only toxic side effect of note.

3. The second, methyl-phenyl-ethyl hydantoin (mesantoin) has proved efficacious in our small series of 11 cases as well as in larger series of other investigators. Skin rash and drowsiness are the only toxic effects of note.

4. Suggestions are outlined for preventing side reactions and for conducting the change-over from sodium diphenyl hydantoin (dilantin) to these drugs.

5. It is concluded that sodium diphenylene hydantoin and methyl-phenyl-ethyl hydantoin (mesantoin) are effective anticonvulsants and are worthy of a place at the side of sodium diphenyl hydantoin (dilantin) in the medical treatment of the major epilepsies.

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Toxicity of Streptomycin

The toxicity of streptomycin now appears to be sufficiently great to deny use of the drug to those patients who are making satisfactory progress under conventional forms of treatment. At present, most experienced physicians prefer to reserve the limited supply for patients more acutely ill, and especially for those in whom the disease has been progressive during recent months, and no other treatment is likely to be effective. Streptomycin is of no lasting or significant benefit to patients who apparently have hopeless, destructive types of pulmonary tuberculosis.—H. McLeod Riggins, M. D., and H. Corwin Hinshaw, M. D., *Am. Rev. Tbc.*, Aug., 1947.

Medical Aspects of Juvenile Delinquency

WILMOT F. SCHNEIDER, M. D.

I would feel that the whole purpose of this paper would be lost if we were to consider delinquency as the final milestone of a child's maladjustment. Our broader purpose should be to think of delinquency as a challenge to our scientific knowledge and to our thinking how we can apply this knowledge to bring about a readjustment of the delinquent's whole personality. At the onset we must consider the delinquent as a psychobiological unit and think in terms of some physical defect as it has caused maladjustment *per se*: the pure case of the child with the brain wave abnormality of psychomotor type who has impulsively stabbed or shot another during a seizure.

Secondly, we must think in terms of the emotional implications integrated with some physical defect. The child with the Fröhlich syndrome who has repeatedly truanted because he cannot face the taunts of his companions when he has to take a shower after gym.

TRUANCY

In either case we, as physicians, or a Juvenile Court, are challenged by James Plant's provocative question, "To what extent can the Court use delinquency as the door to understand what the home, the school, industry, life itself, mean to the children 'delinquent'?" We must immediately reorient our way of thinking when we are trying to understand and help this "delinquent". We must stop being the "parent" who immediately thinks of punishment. We must become immediately the warm, accepting, searching healer. If you are psychiatrically minded you will drastically reshape your thinking about truancy. You will then more easily agree with Plant that "truancy is often the first sensible act in a situation involving the forcing of a child through an impossible school situation".

With this thought in mind it is not a far step to think in terms of the third component of the psychobiological unit: the intelligence; the intelligence and emotions compositely becoming the "psyche" of this unit; the intelligence as it may be affected through the myriad physical, toxic and anoxic enemies waiting to attack and alter it from preconception to "present illness"; the intelligence as it may be unwittingly partially, or totally cut off from the outside world by a part-dysfunction such as deafness, refractive error, association tract damage of the encephalopathies, or lack of expressive powers associated with the spasmophemias.

From the Babies and Childrens Hospital, and the Departments of Pediatrics of the University Hospitals and Western Reserve University School of Medicine.

Read in part before the Annual Meeting of the Ohio State Medical Association in Cleveland, Ohio, May 8, 1947.

The Author

● Dr. Schneider, Shaker Heights, Ohio, is a graduate of Western Reserve University School of Medicine, 1930; member, American Psychiatric Association; formerly (at time of paper), assistant professor of pediatrics, University Hospitals of Cleveland and Western Reserve University School of Medicine; and now, part-time child psychiatrist to Cleveland Heights Board of Education.

It would be amiss for me to omit one facet of this study of the psychobiological unit which has become entangled with the Law through its failure to maintain balance and that thin adjustment. The psychosomatic school adds to our consideration the case of "unconscious malingerings". This is commonly illustrated by the child who attempts to escape the hopeless, inescapable overdemanding of some parents for academic achievement. Whether there may again be some part-dysfunction or intellectual defect, as yet unrecognized, which may contribute to the lack of achievement, the parents selfishly and severely put on pressure for "grades". Teacher says, "He could do better if he tried!" Finally, with or without some mild, antecedent illness, the child escapes the intolerable situation through a form of "neurosis": severe vomiting, abdominal pains, headaches, hysterical blindness. This is as "satisfactory a solution" as any overt truancy. This psychosomatic concept makes us, as physicians, pause abruptly in our thinking! After we have satisfied ourselves that there is no tangible, findable physical cause for all this, we must stop to think! What meaning does this have to the child? From what is he escaping (truancy)? Who actually is the delinquent? As soon as we orient ourselves to these different viewpoints, we can begin to think in terms of what delinquency means to the total personality of the patient.

CLASSIFICATION

A. General Hyperkinesia:

In an early paper about these restless, irritable, tense youngsters I¹ have discussed some specific physical factors contributing to hyperkinetic behavior. We have gone through a cycle of overemphasis upon "focal infection", through a phase of overcaution about mentioning "diseased teeth and tonsils" as possibly associated with behavior disorders. Now we are again cautiously evaluating how the combination of minor intoxications

and part-dysfunctions do contribute to that vicious cycle of fatigue and resultant tensions. This cycle is augmented in the classroom by the teacher's constant haranguing the child to "pay attention", "do better". Companions tease these youngsters, do little things to get them into trouble and get blamed. Principals frantically call for parent-consultations because the hyperkinetic child disrupts the classroom routine through his semi-choreiform antics. Parents descend upon the hapless child! With fulminating overactivity he escapes this unending assault through truancy, setting fire in school, attacking a taunting schoolmate, possibly turning this overwrought aggressiveness upon himself and suicides.

B. Allergy Contributing to Delinquency:

Under this classification can be grouped those restless, unhappy children lacking in concentration; the ones with the constantly running noses, itchy eyes, vague, uncomfortable colic, headaches, the allergy "salute". These are the ones recently called to our attention by Dr. Horesh² in his article, "Allergy in Children". It is little wonder that some of these children steal. Just recently an eleven-year old boy attending private school was referred for psychiatric evaluation because of stealing. "Really I can't understand it, Doctor; he has everything he wants! I can't understand why he steals," says his thoroughly over-anxious mother, a mother who overzealously protects him from every allergen, although the allergist assures me he has the sensitivities well under control through injections. Although mother asserts he has "everything", I find he isn't allowed to have a pet because he was found to be sensitive to dog dander. Although he had learned to be a fine runner, despite his recurrent asthmatic attacks, the mother was afraid to let him practice in Winter because he "was sensitive to gym mat dust". He couldn't have a paper route because he "had a physical allergy with sensitivity to cold and dampness". He couldn't achieve well enough in school because the parental expectations for marks had been set so hopelessly high. He had to study until so late at night, he was too hopelessly fatigued to produce the next day in school. Finally his whole unhappiness, his tensions, his frustration through blocking of achievement in every channel, mounted to such a pitch of emotional instability that he steals. When we begin to thus work out the interrelationship of disease and emotional plus environmental pressures, we can see the cry of the psychosomaticists for the integrated treatment by physician and psychiatrist.

C. General Physical Disorders:

I would like to digress a moment from the consideration of this type to orient our viewpoint

about all of these disorders so far mentioned and to be discussed. This program would have little meaning to this group of family doctors if you felt that I was speaking just as the Court Psychiatrist; that you would only see those cases in such a situation. A deliberate effort has been made to choose cases from the Child Psychiatric Clinic files or from private practice, those cases whose parents would come first to you for relief and solution; those cases whose intelligence is not of the "Special Class" level (I. Q.'s from 50 to 83) or below an I. Q. of 50 of the institutional level.

Another consideration should be, "How frequently are physical abnormalities associated with and contributing to delinquency?" Dr. Richard Jenkin's³ analysis last year of 500 cases of delinquency in Illinois reveals a positive figure from a negative statement that physical "findings were essentially negative" in 47 per cent of those cases. This 53 per cent of the cases in whom physical abnormalities were present corresponds closely with Lurie's 1938 report of 49 per cent endogenous (psychophysical) factors contributing to the behavior disorders studied in his Cincinnati Child Guidance Clinic. In 1940, Dr. E. W. Wallace reviewed the literature to that date and listed the physical defects found in children under the jurisdiction of the Erie County Children's Court. He found only 3 per cent free from some gross physical defects. Although he does not attempt to correlate the emotional meaningfulness of these defects and delinquency, this figure stands as a warning signal pointing to total neglect of the child, lack of parental interest and responsibility, and points to the preventive mental hygiene role of the school and family doctor.

D. Postencephalitic Behavior Disorders:

Let us now integrate the pure physical defect, the intelligence functioning and the behavior. There may be little benefit from quibbling about the etiology of an encephalopathy or encephalitis when we have to deal with the resulting behavior. It is surely an object lesson to the physician to follow the recommended pertussis immunization program in infancy when he is confronted with the post-pertussis encephalitic behavior disorder. Whether the etiology be this, or lead, parotitis, measles, toxic pneumonia, cerebral traumatism, or pure encephalitis, we find that we are dealing with frantic parents, a disturbed, rejecting school, and a severely aggressive, antisocial child. His behavior may run the gamut of stealing, fire setting, swearing, knifing, streetcar hopping, auto stealing, to all brands of sadistic cruelty. Too often the school and parent don't really know what the trouble is. Psychological tests may reveal an "I. Q." which is still "normal" but these tests may also reveal confused, faulty

thinking, poor memory and reasoning, impulsivity in answering, and uncritical judgment. When the content of the child's thinking is scrutinized, there is seen a stereotype; a "one-track-mindedness". It is thus not the "I.Q." which is at fault but how the child thinks and what he thinks. It is this impulsivity and lack of judgment that gets him into trouble with the school and the law. The "I.Q." just doesn't keep him out of trouble. It is this "single-mindedness" which causes a repetition of the same behavior pattern.

The same study and treatment of these cases must be followed as would be carried on in the various forms of epilepsies. We cannot entirely be guided by the electroencephalographic tracings to our choice of drugs. Unfortunately, each case must be individualized and even more unusual combinations of drugs resorted to than we would ordinarily use in the treatment of the epileptic disorders. I shall not discuss treatment here because Lennox⁴ and Peterman have so recently reviewed the growing therapeutic battery which is being given us to help control those behavior disorders. Granted that irreparable damage has been done by the disease, we must accept the challenge of the behavior disorders of these formerly called "bad boys". To those of you to whom the school has turned for help with these children whose short attention span, distractibility, irritability, petty meanesses are finally "driving the teacher crazy", let me recommend a somewhat old but highly provocative book: Elizabeth Lord's *Children Handicapped by Cerebral Paralysis*. It has helped me understand these children and guide the parents and the school toward a much happier adjustment goal in keeping with the psychophysical capacity of the child. For the physician who is confronted with the postencephalitic behavior disorder let me recommend Josephine Neal's book *Encephalitis—A Clinical Study*.

E. Cerebral Dysrhythmias:

A consideration of brain wave abnormality, or dysrhythmia, naturally follows the above discussion. The psychiatrist welcomes the electroencephalograph as a valuable laboratory adjunct but has been reluctant to cry, "Eureka, now we have the final answer to the delinquency problem." Always extreme caution must be used in the interpretation of these records. The warning is heard from all researchers in this field, "know your normals before attempting to interpret abnormality!" Gibbs and Gibbs' *Atlas of Electroencephalography* serves as a worthwhile guide in orientation.

Our primary interest in electroencephalography should be whether a condition is revealed which may be amenable to medical treatment. Our judgment of reports which bring out the per-

centage finding of positive EEG's in behavior cases must be guided by the awareness of the particular group with which the investigator is dealing. When the physician is guided by a carefully taken "Past History" and history of the type of behavior plus the meticulous consideration of the neurological findings, he will find that he seldom orders an EEG which fails to reveal some type of dysrhythmia. The EEG becomes most important in corroborating the differential diagnosis between the aggressively antisocial behavior of the child with the deep-seated, impulsive, obsessive-compulsion tension state and the behavior of the same assaultive, unpredictable type associated with some former central nervous system injury of physical or toxic origin.

a. **General Behavior Disorders with Positive Electroencephalograms:** The study of Strauss⁵ revealed 68 per cent abnormal electroencephalograms in this behavior problem group. Not only were diffuse dysrhythmias revealed but also the localized dysrhythmia which necessitated further neurological study. Strauss exhumes the controversial "epileptoid personality" but gives a classification of behavior which must interest those of us working with delinquents. His three types are: (1) The assaultive, destructive, disobedient type of child with constant irritability and hostility toward the environment; (2) the runaway type with the fugue-like states; (3) the type with episodic temper outbursts showing a relatively normal type of behavior between outbursts.

I scarcely have to call to your attention the significance of this behavior as it would disrupt the home and school environment. Often this child is started on the road to delinquency because the real significance of his behavior is not understood as a true neurophysiological disturbance. A hint about the direction which we can take in investigating these cases by the electroencephalographic method is given by Gottlieb. EEG's were done on the misbehaving child when there was a history of instability in the family and some antecedent illness or injury in the child. The family history might contain such disturbances as psychosis, maladjusted personality (inability to control emotional responses, tendency to "blow up"), chronic alcoholism or epilepsy. In the child's history there might be such suggestive features as: prematurity, birth injury, head injury with unconsciousness, convulsions in infancy and anoxemia at birth or later (the prolonged breath-holding spells of some children may not be so innocent as formerly supposed).

A word about treatment in these dysrhythmias should be inserted here. I have mentioned above the use of anticonvulsants and sedatives in the treatment of the true epilepsies; these should

be tried in our attempt to bring about a better socialization of the disturbed and disturbing child. Perhaps we have failed to carry our therapeutic efforts far enough after phenobarbital has been tried and has either failed or caused an exacerbation of the behavior. We are all familiar with the frequently paradoxical effect of phenobarbital on the child with allergy sensitivities.

b. **Psychomotor Behavior:** When we are confronted with the sudden, unexpected, inexplicable behavior of the child who has blindly assaulted or stolen, we would be amiss in not considering the psychomotor type of behavior. Penfield adequately describes this in his book, *Epilepsy and Cerebral Localization*. This "ictal automatism" should be thought of as two types. The first type is that described by Gibbs and Lennox in connection with the "psychomotor" brain wave pattern: 3 to 6/second, rhythmic, slow waves and the inverted sharp waves (called "square top waves"). This type may be found alone or associated with other types of epilepsies. This post-ictal behavior may follow a major seizure. It may well represent a release of cortical control associated with the violent, automatic behavior; the "robot" performance of the delinquent who says, "I didn't know what I was doing or where I was."

The second type of "ictal automatism" need not necessarily be the post-convulsive, confused state. The psychomotor behavior of this type as a disturbance unto itself is described by Penfield, "a release of higher cortical control through some strong nervous discharge; sudden disturbance in behavior in an epileptic suggesting the possibility of partial or complete automatism. We are unable to deny the existence of true psychomotor seizures and yet the majority of cases of epileptic mania or sudden, temporary irresponsibility of behavior may be explained as automatism, secondary to release from control of a higher center in which discharge is taking place or has taken place."

c. **Psychopathic Personality:** I am not suggesting that the "psychopathic personality type" should be segregated under the heading of "Cerebral Dysrhythmia". Recent investigation of these provokingly unmodifiable, antisocial adults and even children have shown abnormal EEG's in as high as 48 per cent of the group of 151 studied (Hill and Watterson). Possibly we should pray that some direction of our treatment may come from this field. We should also hope that electroencephalography will aid in making the differential diagnosis between the pure psychopathic states and environmentally conditioned behavior. Many physicians, social workers, teachers and parents may be saved recurrent frustration when our combined diag-

nostic battery (anamnestic, Rorschach, EEG) more quickly reveals the diagnosis. The psychopath is the clever, evasive, always innocent victim, "blame-the-other-fellow" delinquent; his winning ways as a child get him countless, undeserved hours of extra help from his teachers; his blaming other children often get them blamed for the psychopath's misdeeds; his repeated debaucheries and depraved asocialities in later life demoralize his own parents, his own wife and family. If the EEG is giving us one possible physical clue which might be amenable to treatment, we should assiduously follow that lead toward therapy. This particular group of delinquents may constitute only approximately 2 to 3 per cent (Healy and Bronner) but the fruitless hours of therapeutic effect may be multifold.

F. **Physical "Part-Dysfunctions" Related to Delinquent Behavior:** Because of our time limitation I am tempted to group these "part-dysfunctions". The emotional implication of disturbances of vision, hearing, speech, oversize or undersize, deformities, endocrine disorders have been suggested under the above headings. Kanner discusses this psychosomatic concept in the second section of his book *Child Psychiatry*. I have elaborated the concept of emotional disturbances arising from part-dysfunction in the earlier mentioned paper "Psychiatric Evaluation of the Hyperkinetic Child".¹ We need only carry this concept of the behavior maladjustment of the hyperkinetic child one step further to see that we are dealing with the potential delinquent. We must realize that the assigned title has necessarily limited the scope of the material to primarily "physical" considerations. I would like to mention Williams' recent article, "Therapeutic Considerations in Prevention of Juvenile Delinquency". He gives an excellent correlation of social, home, and environmental factors. His consideration of treatment techniques and modifiability of the individual well recommend his studies to those of you interested in actual Juvenile Court methods.

Lauretta Bender is doing unparalleled investigation of the emotional disorders of delinquents studied in Bellevue Hospital Children's Wards in New York. The earlier reports on "fire setting" by one of her assistants (Yarnell) very clearly brings out the emotional disturbances associated with reading disabilities arising from visual or auditory defects or confused laterality, with brain wave disturbances, with abnormalities of the intelligence. Dr. Mary Preston in the San Francisco Child Guidance Clinic has clearly shown how physical defects cause the child to turn to radio and the movies for escape; she further shows how delinquency patterns can be laid down through constant "addiction" to the

movies and the radio, addiction which may be just as difficult to treat as the addictions of adults.

SUMMARY

It is this "meaningfulness" of physical defects which must be constantly kept in our minds. The delinquent is sent to us because he has transgressed against society. We must look upon him as a "sick" child. We must go a step farther than simply make the cursory "physical" survey which may reveal a few isolated physical defects. Blumenthal sums up the psychobiological point of view in his statement: "Physicians may be concerned with the physical aspects of disease and defect to the exclusion of adequate consideration of the influence that disease or physical defect may have on personality and behavior." Let us then remember that the delinquent turns to us for study and understanding of his total defective personality. Let us use the tools of investigation given to us through the use of the psychobiological study method, the psychosomatic correlation, the electroencephalographic investigation, and the judicious use of pharmacological and psychiatric treatment.

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Vagotomy

An attempt to reach a uniform conclusion concerning vagotomy today that would apply to many different clinics and centers ends only in confusion. It is known that in a series of dogs that had undergone bilateral complete interruption of the vagus nerves by the transthoracic approach, the initial achlorhydria later was replaced by a definite degree of free acid in the stomach. In some of these animals, the pre-operative level has been reached five years after the operation, and even at the end of five years some of the stomachs still revealed a markedly dilated state suggesting definite atony. However, one cannot overlook the fact that the early results being reported by the best investigators and having included a follow-up period of more than three years indicate that many patients are still completely well. This emphasizes the fact that other effects of vagotomy need not be considered too important. Abdominal distention has been reported but its exact nature is not entirely understood. E. S. Judd, Jr., M. D., Rochester Minn. *Jrnl. of Kansas Medical Society*, Vol. XLIX, January 1948.

Keeping Up With Medicine

- ALMOST half a century has elapsed since the scientific world entertained its first suspicion that certain human diseases might spread through the agency of insects.

* * *

- CONGENITAL malformations of the heart are associated with a high incidence of German measles on the part of the body early in the pregnancy

* * *

- PROTAMINE zinc insulin is more frequently the cause of local allergic reactions in the skin than the other forms of insulin.

* * *

- EXAMPLES of conditions which may be allergic in Nature now includes rheumatic fever, glomerulonephritis, periarteritis nodosa, Buerger's disease, and disseminated lupus erythematosus.

* * *

- OPSONIC test is not recommended as a proper procedure in a patient in whom one wishes to confirm the diagnosis of undulant fever as only very strong reactions may be significant.

* * *

- IF man were to retain the heat that he produced by his internal combustion in one hour at rest, his body temperature would rise more than two degrees (F.).

* * *

- IN highly resistant and severe cases of contact dermatitis of the eyelids, lasting for a long time, one should not forget the possibility of malingering or hysteria.

* * *

- EPILEPSY can lay claim to the longest history of any disease in medical literature.

* * *

- POSTNASAL drip is not so simple when one tries to determine its cause for there are at least 23 separate and distinct etiological factors.

* * *

- PARENTS should remember that their children imitate them and will take on, therefore, their habits, good or bad. The habits of a person make him what he is.

* * *

- IN a broken home, through his acquired sense of insecurity, the child either develops inferiorities, insecurities, or anxieties, or he will constantly be in mischief and so try to get attention. All of this makes for a weak personality.

* * *

- THE cranial nerve most frequently involved in "bulbar" poliomyelitis is the eleventh.

* * *

- THE failure to hear the tick of your watch, though not reliable, does give some information as to the relative hearing ability of the two ears. —J. F.

Present-Day Concepts of Rheumatic Fever

ALEXANDER T. MARTIN, M. D.

A disease which attacks 1 per cent to 4 per cent of our school population (an estimated 200,000 children between 5 and 19 years) and 1 per cent of our wage-earning population in this country, should merit our attention, interest, and concern. Such a disease is rheumatic fever and rheumatic heart disease. The mortality rate, as is the morbidity rate, is high. An estimated 40,000 die each year with 30 years the average age at death. An estimated 800,000 to 1,000,000 persons have rheumatic heart disease in this country, contracted in most instances in early childhood. Up to 40 years of age rheumatic fever is the great cause of cardiovascular disease. It is essentially a disease of childhood and appears as an initial infection about seven years of age when the boy or girl has begun his schooling and soon after the second dentition has begun to make its appearance. The high incidence rate at seven years falls as adolescence is reached when primary infections become less and less frequent. It is for this reason that the frontal attack on rheumatic fever should be made during these early critical years of the child.

A characteristic of the disease, which is more often the rule than the exception, is that it tends to recur. The recurrence rate is unpredictable and it is this polycyclic tendency which makes prognosis so difficult. Unlike poliomyelitis, which strikes but once, rheumatic fever may occur again and again. Each episode or bout leaves the heart more and more damaged, and it is this which makes the disease such a serious one.

Very few children who contract rheumatic fever escape without some damage to the heart of greater or less degree. It has been well said that "a child with a withered leg can see his own infirmity, and seeing it, understand it. A child with a crippled heart cannot see his injury; he must be told, and, having been told, believe it. He must suit his life to an intangible infirmity that imposes its limitations on all of his physical activities." In one sense the child stricken with infantile paralysis (as dread a disease as it is) is more fortunate than the child stricken with rheumatic fever. The latter confers little if any immunity and one attack may be followed by a number of repetitive attacks, each one causing more and more damage to a heart already damaged.

Read before the Section on Pediatrics at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947.

The Author

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DIAGNOSIS

To those of us who are practicing pediatrics our task is the recognition of the disease, in other words diagnosis. This must be the sine qua non of our professional responsibility. Because rheumatic fever is so polymorphic and bizarre in its manifestations, this makes it one of the most difficult of diagnostic problems. In many cases only time and frequent observations can give an answer. It is not easy, for instance, to determine the character of nervous tics or the meaning of so-called "growing pains". In the former these nervous movements may or may not be the onset of an incipient chorea and in the latter, the leg pains may or may not be the beginning of a sub-clinical type of rheumatic fever.

I am convinced that it is often more important (and usually more difficult) to make a diagnosis of "no rheumatic fever" than to make a diagnosis of "rheumatic fever". For I have seen too many children who with indeterminate symptoms and the finding of a heart murmur have been diagnosed as rheumatic carditis, treated as such and kept in bed for long weeks and sometimes months. This is indefensible and builds up for the child an "invalid reaction" with feelings of inferiority, inadequacy, and insecurity. Many of these children will grow up into adulthood and constitute many of our cardiac neuroses.

HEART MURMURS

The correct interpretation of heart murmurs becomes one of our most important responsibilities as physicians. The physiological, functional, or accidental murmur should be differentiated from the hemic, the congenital and the organic murmur of the heart. The functional basal systolic murmur in the growing child is a frequent finding and is more often the rule

than the exception. It is these functional murmurs which are often misinterpreted resulting in a denial and restriction of the normal life and activities of the child and in many instances subject him to long weeks or months of invalidism. Now that cardiac surgery has brought such brilliant results in the amelioration of congenital heart disease, an accurate interpretation of cardiac murmurs becomes even more important and brings an added responsibility to those of us who serve in diagnostic cardiac clinics. It becomes important, for instance, to determine if a heart murmur or murmurs is produced by a patent ductus arteriosus, or a co-arcuation of the aorta or a pulmonary stenosis with or without the tetralogy of Fallot. So, this new field of remedial surgery brings with it a challenge and adds a clinical interest in cardiac diagnosis and treatment.

In the diagnosis of rheumatic fever we should differentiate between it and rheumatic heart disease. This is of paramount importance for it must be remembered that many months may elapse, following the initial infection, before clinical evidence (by the ear) of carditis is discovered. It takes time for a mitral valve, for instance, to become curled and shortened before incompetence of that valve can be detected. By the same token that a child with poliomyelitis is often not diagnosed until he is out of bed and found to be limping, so it is that rheumatic carditis may not be discovered until long after the initial infection.

It is in the school where early cases of rheumatic fever can be detected and it is here where many can be screened out. The teacher is in a particularly good strategic position to do this. Teachers should be trained to be more health conscious regarding their pupils. Many of them are, but this is not universal.

SYMPTOMS

The child who is below par, who tires easily, is losing weight, has general lassitude, and is becoming more pallid should be reported to the school doctor or nurse. If neither are available then the parent should be informed and in turn the family physician consulted. I do not mean to imply that the aforementioned symptoms indicate that the child has rheumatic fever. Such is not the case. They may be far removed from the rheumatic state and may be indicative of some other condition. But they can be early symptoms of the disease under discussion and should not be minimized.

Also early cases of chorea can be screened out by the teacher and reported to the doctor. It then becomes his responsibility to differentiate between true chorea and habit spasms or tics, a diagnosis often none too easy. These

children are usually girls in the pre-adolescent or adolescent age.

We come now to "growing pains". These make for the physician one of his most besetting problems. Certainly not every child with "growing pains" has rheumatic fever but some of them do. These pains, usually in the legs and complained of mostly at night, may be due to the process of growth combined with a fault in body mechanics. Many are due to weak and pronated feet with a resultant faulty posture. Other children complain of leg pains at night simply from over-fatigue. In others there is a psychic element, the complaint being an attempt on the part of the child to gain the attention of the parent. The differential diagnosis of "growing pains" is not easy and may require time and observation.

Rheumatism and joint pains are usually synonymous and often associated. But polyarthritides evidenced by painful, tender, red, hot, and swollen joints is not so common in the child. The younger the child, the less apt are the joints to be involved. It is for this reason that many cases of rheumatic fever remain undiagnosed. Some of the most severe cases of rheumatic carditis which I have seen have been those in which there has been no preceding history which would suggest joint involvement.

Other signs and symptoms as recurrent abdominal pain (sometimes simulating appendicitis), skin rashes (erythema multiforme), frequent nose bleeds, subcutaneous nodules, choreiform movements, any or all of these may be associated with the rheumatic state.

Fever and tachycardia are associated with the acute phase. The latter is one of the most reliable clinical signs we have to indicate activity, particularly the characteristic gallop rhythm often heard at the apex of the heart. The importance of the increased heart rate as a sign of active carditis was stressed many years ago by Sir Thomas Lewis. Recording of the sleeping pulse is an important part of the observation.

In nearly every instance of rheumatic fever the heart is involved to a greater or less degree. This is why it is so serious and becomes the chief etiologic factor in young adults with heart disease. The degree of cardiac involvement is directly proportional to the number of recurrences and these, in turn, usually determine the life span of the individual. The Aschoff body has been found by Von Glahn in the myocardium 44 years after the initial infection. I state this to indicate the chronicity of the disease. Other structures and organs of mesenchyme origin are often involved in the rheumatic process, such as the blood vessels, the pericardium, the pleura, the peritoneum, the lungs, the kidneys, and the brain. We are too prone to think

of rheumatic fever in terms of heart disease rather than as a generalized infection affecting many structures.

Three phases have been postulated in the course of the disease. Phase I represents the initial infection, usually a sore throat (a pharyngitis or tonsillitis) with fever, caused by a Group A hemolytic streptococcus. Phase II follows as a quiescent period of two to three weeks. This is the pre-rheumatic phase in which certain still obscure immunologic reactions in the susceptible individual occur which ushers in Phase III. Phase II is without symptoms. Phase III is the rheumatic fever phase, which, if we knew how to prevent, we would solve the problem of rheumatic fever.

Encouraging progress has been made in reducing the number of hemolytic streptococcus infections of the upper respiratory tract (Phase I) with the use of the sulfonamides as chemoprophylaxis. The carrier rate has also been reduced.

PROPHYLAXIS

Extensive chemoprophylactic programs with sulfadiazene by the Army and Navy have shown a lowered incidence rate of streptococcal infections, with a corresponding lowering in the cases of rheumatic fever. It is possible that certain antibiotics as penicillin may be even more effective in the prevention of streptococcal infections. This is still to be evaluated.

However, two words of warning are necessary. Beside the serious toxic effects which may follow the use of the sulfonamides, there is the real danger of building up many drug-resistant strains of bacteria which may militate against their effectiveness when catastrophic and serious illness strikes. This is a real danger both in regard to the use of sulfonamides and also in the use of the antibiotics as penicillin.

It is unnecessary to state here that both the sulfonamides and the antibiotics are not only contraindicated in the treatment of rheumatic fever but they may do more harm than good. What I have had to say about them has been directed towards their use as prophylactic agents against the initial hemolytic streptococcus infection and the streptococcal carrier rate.

Penicillin is now strongly advised in an individual who is a known rheumatic, prior to any operation on the teeth, the tonsils and the sinuses. The purpose of this is to prevent a possible sub-acute bacterial endocarditis.

ETIOLOGY

The cause of rheumatic fever is not known, but the hemolytic streptococcus has been generally accepted as a pre-disposing and exciting factor. This organism has been likened to a

detonator which sets off a charge in the susceptible individual.

Many interesting theories in etiology have been advanced. There is the theory of allergic sensitization of mesenchymal tissues by sensitizing antigens. This has been compared to serum sickness, the counter-part being the fever, the rash and the joint-pains which follow the use of horse-serum. But the analogy stops here. There is the hypothesis of a type specific strain of streptococcus, supporters of which claim that the clinical range and proportion of disease produced by a given streptococcus are specific characters of that strain. There is the theory of enzyme response in which some enzyme such as hyaluronidase may play some part in the production of the disease. And so the field is open for speculation and for further research.

TREATMENT

What can be said about treatment? There is no specific therapy. As I have previously stated the sulfonamides or penicillin may do more harm than good. The drug of choice in the acute and sub-acute phase of rheumatic fever is salicylate. This should be given in larger doses than we have hitherto used it, in the form of sodium salicylate or as aspirin or empirin. Salicylate should be given up to the tolerance of the individual patient short of toxic effects. The desired plasma salicylate level is 35 mgm. per 100 cc. blood. This can usually be maintained in the young child by giving about 0.1 gm. of salicylate per kilogram of body weight, which means that a child of five years weighing 45 lbs. would receive 30 grains a day. During the acute phase of the rheumatic infection this should be spread over the twenty-four hours at four-hour intervals. Older children and young adults may require larger dosages (0.2 gm. per kilogram) to attain the plasma level desired. Mouth administration has been found satisfactory and is preferred over the slow parenteral infusion as has been advocated. A practical method has been worked out for quantitating the salicylate concentration in the blood which has proved useful in treatment.

Sodium bicarbonate should not be used with salicylate in the treatment of rheumatic fever. This is a time honored and accepted use of a drug which was presumably given to allay gastric irritation. It has now been shown that bicarbonate lowers the plasma salicylate level by three possible means, first by increasing the excretion of salicylate through the kidneys secondly by raising the PH of the gastric acidity, thus slowing absorption, and thirdly by increasing extra cellular fluid, thus decreasing salicylate concentration in the blood. Therefore, to give bicarbonate with salicylate is to defeat our purpose. Without it the larger doses of salicylate are not so necessary, and the optimal plasma

salicylate level of 35 mgm. per 100 cc. can better be maintained.

TOXICITY

The toxic effects of salicylate have been repeatedly recorded and should be watched for. Such symptoms as deafness, tinnitus, delirium and hypernoea are red lights and may be the onset of a severe and serious acidosis. If acidosis is suspected, the CO₂ combining power of the blood, a reliable index of acid-base balance, should be determined.

Salicylates do not cure rheumatic fever. They do have a favorable effect on the exudative phase of the disease but fail to influence the proliferative lesions. It has been claimed that high dosage of salicylate will make the patient more quickly asymptomatic, will prevent carditis and bring the erythrocyte sedimentation rate more quickly to normal. These results have not been obtained by all other workers and should be further evaluated.

When to stop salicylate always poses a good question. In general, if the patient is asymptomatic, the drug can be stopped two weeks after the sedimentation rate has reached normal. The salicylate dosage should be tapered off during this time.

An untoward effect of large doses of the drug over a period of time may, in certain individuals, lower the prothrombin of the blood giving a tendency to hemorrhage. A knowledge of this fact will guide the physician in his treatment and he will order vitamin K to combat this hypo-prothrombinemia. It is important to keep in mind this effect of salicylate upon the blood clotting mechanism.

BED REST

Bed rest is still the treatment of choice for the child with acute and sub-acute rheumatic fever. This may have to be prolonged over a long period of time. Bed rest is just as important for the child with rheumatic fever as it is for the child with tuberculosis. It is a conserving process for a vital organ already damaged and is the most effective therapeutic measure we now have. If, by bed rest, the heart can be slowed 10 beats per minute, it is thus possible to save this organ about 15,000 less systolic contractions in twenty-four hours.

A difficult problem for the physician is to decide when bed rest can be terminated and graduated activity begun. Each patient should be individualized, for no general rule can be followed. The erythrocyte sedimentation rate is at present our most reliable and sensitive determinant of activity or non-activity. Even this is not always specific or infallible and may remain elevated for many weeks, even after other signs of clinical activity are no longer evident.

Important diagnostic aids are the X-ray, the fluoroscope, and electrocardiography. The pro-

longation of the auriculo-ventricular conduction time as indicated by the prolonged P-R interval is a frequent finding in active carditis. Recent electrocardiographic studies show the value of the routine use of multiple unipolar precordial leads in detecting certain changes in cases of rheumatic heart disease not detected by the ordinary leads. Such changes may be an alteration in the ventricular complex, either the QRS, the S-T segment or the T wave. Also, irregularities in the cardiac rhythm may be found.

SUMMARY

In summary I would like to stress a few major points.

1. Rheumatic fever is essentially a disease of childhood.
2. It tends to be polycyclic.
3. There is a close association with the Group A hemolytic streptococcus.
4. It tends to occur in families and there is a hereditary susceptibility.
5. It is a disease of the lower economic group in which poverty, malnutrition, over-crowding, cold and unsanitary conditions play an important role. However, these environmental factors do not explain the high incidence of rheumatic fever in the military services in both World Wars. In some camps in certain areas of our country, the disease became a major health problem. Almost always there was a close correlation with hemolytic streptococcus infections or a high streptococcal carrier rate.
6. It is a seasonal disease, the peak of cases being found in March, April, and May.
7. It is a climatic disease in that it is not common in tropical zones.
8. It has a high death and crippling rate. In children, the deaths are due to the rheumatic infection and not to congestive failure as is more often encountered in adults.

SOCIAL ASPECTS

I know of no disease of childhood in which ecology plays a more important part than does rheumatic fever. The whole field of social medicine should share in its control. This means a cooperative team work on the part of the physician, the public health nurse, the medical social worker, the parent, and, last but not least, the teacher in the school. Only in this way can we hope to attain our objectives. To supplement these, more intensive research is necessary. Community programs should be set up, registries should be started, and school health programs should be established to screen out suspected cases.

With these and diagnostic and care facilities made available to the practicing physician we can go a long way in bringing this serious disease and public health problem under control.

Soils and Health

PAUL B. SEARS, Ph.D.

THESE are between three and five million acres of land in Ohio which are not well suited to agriculture. It has frequently been suggested that this inferior land would be ideal for game production. Unfortunately, we know that land which will not produce healthy crops and livestock is not much good for the production of wildlife. The statement can be extended to cover people as well as rabbits, pheasants and squirrel.

No doubt a goodly number of Ohio doctors have attended the Kentucky Derby at one time or another. If so, they have been impressed by the beautiful pastures, homes, and farm buildings of the Blue Grass region. The quality of horses bred there speaks for itself. But the secret of the Blue Grass region lies neither in the fine breeding stock nor in the skill and wealth of the owners. It is to be found instead in the abundant calcium and phosphorus of the soil. Where these have been exhausted, as sometimes happens, the best pedigrees and trainers fail to produce winners.

The situation repeats itself in the phosphate basin of Tennessee, the limestone regions of Missouri and Texas, and the Osage Hills of Oklahoma. In all of these places the livestock is vigorous and the people are prosperous.

PEOPLE, TOO

Yet every one of these favorable areas is surrounded by mineral deficient soils and there the contrast is startling. In less than a hundred feet one may move from a thriving, well-to-do region to the other extreme. Livestock grown on the poor soils just outside the Blue Grass or the other rich areas I have mentioned, is inferior. It exhibits defects in posture, development, and vigor that are unmistakable. The people who live on these inferior soils are poor—a situation often, but unjustly, attributed to a lack of enterprise. The late Carl Blackwell, then Dean of Agriculture at Stillwater, Oklahoma, a man thoroughly familiar with the South, told me that he had repeatedly observed the same defects of posture, development, and vigor in human beings that are found in animals grown in these deficient areas. While Dean Blackwell was not a physician, he was a competent scientist. I may add that my own observations support his.

Several years ago I was driven through the region around Spartanburg, South Carolina, by

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The Author

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a quarry operator. The soils there are derived from granite, and are now heavily eroded. Aside from potassium, few of the important mineral nutrients are present in any large amount, even in the topsoil. The low economic status of the eroded land was evident. My guide remarked, "We have to keep a special table to feed up the workmen who come to us from this territory. Otherwise they are physically unable to do a good day's work." Presently we reached an area that had escaped erosion. The topsoil, although far from perfect, was still in place. Buildings and fences were well kept. Then I was told that men who came from these homes were vigorous and satisfactory workmen.

Other indications of the influence of soil that may be noted are as follows:

- (1) The bone weight of livestock of identical age and breeding may be only one half of normal in those raised on deficient soils.
- (2) The calcium content of vegetables and the iron content of milk respond definitely to soil composition.
- (3) Vitamin C content in tomatoes can be tripled by a trace of added manganese, and vitamin A in apples increased by the addition of needed boron.
- (4) The vitamin and fat content of milk certainly respond to dietary differences.

WE NEED TO KNOW

The situation with respect to minerals in milk is not so clear. I have found a tendency among American workers to assume that the calcium and phosphorus levels are maintained on any diet and that milk is thus protected, the direct effect being upon quantity, not quality. In Great Britain there is certainly experimental evidence to support the belief that mineral composition of milk is considerably affected by diet. If prices were as sensitive to calcium and phosphorus content as they are to butter-fat percentage we should see this debate ended promptly by scientific experiment, one way or the other.

Under the Bankhead-Jones Act of 1935, a

number of regional research laboratories have been established by the Department of Agriculture. One of these nine laboratories, located at Ithaca, New York, has been charged with investigating the problem of nutrition from soil to plant, to animal, and from animal to human being. This is exactly the kind of information that is needed.

In *Science* for April 18, 1947, Dr. Leonard A. Maynard, Director of the School of Nutrition of Cornell University, discusses the problem of nutrition, presenting what I regard as a conservative position. Since he should be quite familiar with the work of the regional laboratory at Ithaca, his remarks have special interest.

Noting the importance of discoveries already made through the study of laboratory and farm animals, Dr. Maynard stresses the need to push such work as far as possible before using human beings as guinea pigs. What is true for the lower animals is not necessarily true for man, but nutrition for both begins with the soil. Experience with grazing animals has demonstrated the importance of phosphorus, copper, calcium, and other minerals in the soil. Dr. Maynard's comments on cobalt are striking. "It has been found," he says, "that .1 mg. of cobalt daily makes the difference between life and death in a sheep; a lack of this minute amount was responsible for the death of tens of thousands of animals yearly before the discovery was made. This mineral is probably unimportant in human nutrition, but we are not sure about this."

AN ADVANCED GUARD

Dr. Maynard also emphasizes the need for fundamental studies on the relation of soil and soil treatment to the mineral content of plants and to protein and vitamin metabolism as well. In his words, "We are very ignorant of this phase of plant physiology." He deplores the statements of enthusiasts and responsible writers warning of the dangers of food from deficient soil, and asserts flatly that no alteration of the ration, much less of the soil, can influence in any significant way the amount of calcium, phosphorus, protein, or iron an animal puts into its milk or muscles. In view of his plea for further research, I find this dogmatic statement somewhat disconcerting. As I have said, it represents the prevalent view of American nutritionists.

Whatever censure may be due to the enthusiasts and responsible writers whom Dr. Maynard chides, they form a very lively Advance Guard which is responsible for growing popular interest in the relation of Soil to Health. The group includes, among men with a background of professional scientific discipline, Dr. William Albrecht of the Missouri Experiment Station, Dr. Jonathan Forman, editor of the *Ohio State Medical Jour-*

nal, and Dr. Weston Price, formerly of Cleveland. It also includes publicists with a considerable measure of practical experience, such as Sir Albert Howard, Louis Bromfield, and J. E. Faulkner. It is not surprising that active Soil and Health cults have grown up around the fringes of this Advance Guard. The main tenet of such groups is that, by promoting normal biological processes in the soil and returning all possible organic matter to the soil, healthy plants, livestock, and human beings will be produced. At times some of the more enthusiastic overdo things—for instance in their denunciation of all artificial fertilizers. But they are, in general, on the track of a very important truth.

Those who insist on the importance of soil in relation to health are not working blindly. Aside from specific facts such as I have already cited, they are drawing upon a respectable body of knowledge which deals with the large relationships in nature. I refer to the science known as ecology, whose principles they are attempting to apply.

THE RULES OF THE GAME

Ecology, like all of natural science, rests upon the laws which govern the behaviour of energy and matter. These laws postulate order in all physical processes. They also express a universal tendency of every process to work toward a condition of equilibrium. The processes whereby life and environment are interrelated are no exception.

Natural soil tends to develop, through the constant activities of generations of plants and animals, towards a higher level of efficiency in the use of energy. The ultimate level reached depends upon the particular climate and water supply. It also depends upon the minerals present in the surface material, but differences in this respect tend to be modified by the action of animals, wind, and water which bring in materials from outside. It is for these reasons that a natural, or virgin soil is as a rule highly productive, and its products wholesome.

Man is a relative newcomer on the earth, having been present for a doubtful two million of the two billion years of earth history. He therefore has the benefit of a long process of preparation, both in the evolution of suitable types of plant and animal life, and the development of a very specialized habitat. He is not the independent lord of creation that he imagines himself to be, but rather the lucky inheritor of a very specialized set of conditions. Yet it is his perverse genius to destroy the very kind of environment which he must have to survive. In agriculture his first action is to remove the natural cover which has produced the virgin soil. Unless his practices are extremely skillful they expose the

topsoil to removal and arrest the process of its development and maintenance.

LAND USE BAD AND GOOD

A great deal of what has been called agriculture had better be described as mining. It is exploitation, pure and simple. Such crops as tobacco and wheat make heavy demands upon the minerals of the topsoil, which are thereafter sold off the land. Clean tilled crops, such as corn, tobacco, and cotton, expose the ground between rows to washing. In this way amounts of topsoil running from one to 15 tons per acre or more may be lost annually, and the slowly accumulated minerals go along. Moreover, the water-holding capacity of the soil is lessened, and water runs away instead of being stored underground. The amount of plant and animal remains is reduced, so that beneficial soil bacteria have nothing to live on.

In contrast, good land practices follow the model of nature. As much of the ground is kept in continuous cover as possible. Minerals which leave the farm in the form of finished products are returned to the soil in equivalent amounts. A balance between plants and animals is maintained, so that organic material is kept on the farm.

On a larger scale, this should apply to the wastes of cities where farm products are consumed. It is estimated that the city of Cleveland, which now burns its garbage, destroys daily organic matter equal to that produced in one year by a 300-acre farm. Properly conserved, this would yield considerable fat for industrial use, and organic fertilizer which is badly needed on the truck farms which feed Cleveland.

We cannot as yet trace all of the clinical consequences of eroded and depleted soil. But we do have ample scientific evidence that the capacity of such soil to produce and sustain healthy human communities is low, and that human depreciation runs parallel to soil depletion. We know better than to tolerate what has been happening.

There are over six million farms in the United States, and more than 230,000 in Ohio alone. In contrast, the production of steel, automobiles, rubber, and aluminum are each highly concentrated in the hands of a few companies. It is no wonder that scientific management in industry is far ahead of that in farming.

WHAT WE CAN DO

Great advances have been made in the past fifteen years, but they are a mere drop in the bucket. The necessary reform in soil management is a stupendous problem, calling for the cooperation of every possible agency. The most effective means we have is through the organization of Soil Conservation Districts usually embracing an entire county in each district. A technical

expert is then furnished by the government, but the farmers elect a committee to decide upon the practices they will follow.

Where these districts are in operation it has been found that soil, moisture, minerals, and organic matter are conserved. The level of production and farm income improves, and unquestionably the quality of crops and livestock is raised. It has also been found that the interest and influence of city groups is an important factor in establishing these districts. I would say, therefore, that the most direct and practical action that the Ohio State Medical Association could take on this question of the relation of soils to health would be to encourage, by every means in its power, the formation and operation of such districts. In Ohio several counties, representing some of the best agricultural land in the state, are not yet organized.

As a second measure, I should urge attention to the proper conservation of sewerage, garbage, and other urban wastes which ought to be processed and returned to the land. There is need, too, for more adequate health service, especially in rural areas. Attention should be given to faults of posture, signs of lowered vitality, and other evidences of malnutrition. In this undertaking, especially in the calcium deficient areas of the state, I would strongly urge that medical men exchange information with the veterinary profession which is in a position to recognize the immediate and direct effects of soil deficiencies, and also with soil scientists.

I have no doubt that detailed research will presently indicate what clinical measures, if any, are needed to meet problems arising from the soil. But in the meantime I am certain that the simple measures I have suggested will go far toward making the ultimate use of clinical procedures unnecessary. The good physician is after all, fundamentally a conservationist. And the ideal of a good conservationist is to work himself out of a job.

Rumination

Between the third and sixth months of life this is not an infrequent finding. It is easily recognized by observing the typical tongue and lower jaw forward and slight head extension attitude of the baby. The infant makes rhythmic chewing movement, bringing up food which is then non-forceably ejected or drooled from the mouth. Treatment consists in giving thick feedings or semi-solid foods, distraction of the child's attention and in severe cases where the weight curve starts declining, the use of a rubber balloon at the cardiac end of the esophagus after feedings.—Donald E. Nelson, M. D., Safford, Arizona, *Arizona Medicine* Vol. 5, No. 1, January 1948.

The Surgical Conditions of Infancy

DONALD M. GLOVER, M. D.

THE majority of acute surgical conditions of infancy and childhood are characterized by obstruction in some part of the gastrointestinal tract. The high mortality which still attends many of these conditions attests to the difficulties in diagnosis and surgical management which they present. This discussion will be limited mainly to consideration of the diagnosis and management of these obstructive phenomena.

Intestinal obstruction in the newborn, due to a congenital anomaly, occurs infrequently and often catches the obstetrician, the pediatrician, and also the surgeon unaware. Any newborn baby vomits or regurgitates with sufficient frequency so that these are not regarded as significant symptoms; but when he vomits bile, or when he vomits in the presence of abdominal distention or in the absence of stool, or when his vomiting is projectile, these findings demand immediate investigation. Until proven to the contrary, the assumption should be that the baby has a point of atresia somewhere in the intestinal tract. In most such instances a flat roentgenogram of the abdomen will make the diagnosis.

Congenital obstructive lesions of the gastrointestinal tract may be caused by complete occlusion (atresia), incomplete occlusion (stenosis), volvulus of an incompletely rotated bowel, and obstruction due to herniation of the small intestine through mesenteric defects. The atresias may be single or multiple, the commonest sites being in the esophagus, duodenum, ileum, and rectum. Stenosis may be due to an intrinsic defect or to congenital bands or points of abnormal fusion of the peritoneal layers. The fault in development which causes these abnormalities occurs during the second or third months of fetal life. The mechanism of the production of such defects has been discussed in other communications.

ESOPHAGEAL ATRESIA AND TRACHEO-ESOPHAGEAL FISTULA

The congenital anomaly of the gastro-intestinal tract which is most likely to be discovered soon after birth is esophageal atresia, with or without tracheal communication. The most common type of tracheo-esophageal lesion is that in which the proximal esophagus ends in a blind pouch, while the distal portion communicates with the trachea just above the carina. Esophageal stenosis or atresia may, however, occur alone. When a communication exists be-

The Author

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tween the esophagus and trachea, the newborn infant coughs violently and brings up the fluid swallowed together with froth. Fatal pulmonary infection is almost inevitable within a few days unless operative intervention is successful. When the esophagus ends in a blind pouch, water or milk is regurgitated almost as soon as it is swallowed, and the danger of aspiration into the trachea from the pharynx is great. The diagnosis is confirmed by passing a small catheter into the blind pouch, with or without the introduction of a small amount of barium. If the roentgenogram shows air in the stomach and intestines, the presence of a communication between the trachea and the distal esophagus is confirmed.

Until a few years ago attempts at operative repair of these lesions were almost uniformly unsuccessful, but with improved methods of anesthesia and supportive therapy, several successful cases have now been reported, using a right trans-thoracic approach.^{2,3} In cases where there is not sufficient length of esophagus to permit an anastomosis, the proximal blind pouch must be brought out in the neck to prevent aspiration, with the eventual possibility of constructing a subcutaneous esophagus on the thoracic wall. A gastrostomy for feeding purposes must be established at once in either event.

INTESTINAL ATRESIA AND MALROTATION

The vomiting of bile-stained gastric contents within a few hours after birth is almost diagnostic of atresia of the duodenum distal to the ampulla of Vater. Vigorous peristaltic waves are visible after a feeding, coursing from left to right over the upper abdomen, followed by projectile vomiting. Roentgenograms of the abdomen show a gas-filled stomach and first part of the duodenum, without evidence of gas elsewhere in the intestinal tract.

Illustrative Case No. 1.

This was a premature infant weighing two and one half pounds whose vomiting was projectile from birth, the contents being bile stained.

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Accepting a practically negligible chance of salvaging the tiny infant by any means, operation was performed under procaine anesthesia eight hours after birth. A ring pancreas was found to surround the duodenum just proximal to the ampulla of Vater. This was divided, but a small catheter passed through the stomach disclosed a point of atresia within the duodenum at the same site. A rapid gastro-jejunostomy was performed. The jejunum contained bile. Repeated tibial bone marrow infusions of whole blood were given, the baby took feedings and passed small, normal stools, but succumbed on the fourth postoperative day.

* * *

In a previous report¹ a case of duodenal stenosis due to ring pancreas was reported in which division of the "ring" and gastro-jejunostomy were successful. The mechanism of development of the ring pancreas was also discussed.

DIFFERENTIAL DIAGNOSIS

When the point of atresia is proximal to the ampulla, the vomitus does not contain bile. The X-ray picture is, however, the same as that previously mentioned. In cases of duodenal or upper jejunal stenosis caused by a congenital band, mesenteric defect, or volvulus due to malrotation of the colon, obstruction may not be complete at birth. Vomiting may not begin immediately, and enough milk may pass to produce a small stool. The vomitus contains bile, however, and visible gastric peristalsis is common. The gas shadow of stomach and duodenum may closely simulate that associated with duodenal atresia, but a small amount of gas may also have entered the small intestine. This fact may be confirmed by the introduction of a small amount of thin barium into the stomach. As the stomach and duodenum distend, obstruction is likely to become complete during the first few hours or days of life, and the earlier the true condition is recognized and operation performed the better the little patient's chance of survival will be.

Illustrative Case No. 2. (Previously reported)⁴

A healthy-appearing male infant of almost eight pounds began to have projectile vomiting the first day after birth and continued to vomit with increasing frequency until seen by the pediatrician and surgeon on the seventh day. The vomitus had contained bile. He had passed meconium stools on the first day and an occasional yellow or brown stool on the second to fifth days. He had no stool on the sixth or seventh days. When seen he was markedly dehydrated and showed upper abdominal distention with marked visible peristalsis in the upper abdomen, coursing from left to right. Roentgenograms taken following ingestion of a small amount of barium showed marked dilatation of the stomach and duodenum, with only occasional flecks of barium reaching the small intestine. Barium by rectum showed the colon to be entirely on the left side of the abdomen, in the unrotated fetal position. The fact that obstruction had not been quite complete, the presence of bile in the vomitus, and the position of the colon, all made it seem likely

that the baby's obstruction was due to volvulus of the unfixed bowel (which usually angulates near the duodeno-jejunal junction) or to an anomaly of peritoneal fixation. Exploration revealed the obstruction to be due to three factors: A band across the distal duodenum, constriction of the first part of the jejunum where it passed through the mesentery, and a clockwise volvulus about the unrotated cecum. No intrinsic point of obstruction was present. The band was severed, the point of constriction was relieved, the volvulus reduced, and the cecum was placed in its normal position on the right side of the abdomen. The infant made a rapid recovery. It is interesting to note that although the cecum was not fixed in its new position by sutures, roentgenograms taken five years later show that it has remained in normal position.

* * *

Atresia of the ileum may be either single or multiple. The infant usually shows abdominal distention at birth or shortly thereafter, and soon begins to vomit. After the passage of meconium the first day, there is no stool. Peristalsis may be visible but it is often masked by the generalized abdominal distention. Vomiting may begin with the first feeding or may be delayed for several hours. The vomitus contains bile. The loop of ileum proximal to the point of atresia may perforate during or before birth, in which case liver dullness is obliterated by generalized tympany over the entire abdomen, as illustrated in the following case report.

Illustrative Case No. 3.

A premature, female infant was seen on its third day of life. She had begun vomiting on the first day, and during the twelve hours prior to examination had vomited all feedings. The vomitus contained bile. The abdomen was uniformly distended with drum-like tympany throughout. The skin was stretched so that the superficial veins were easily visible. The baby had passed a little meconium on the first day but nothing since. Rectal examination with the little finger showed the rectum to be patent for a distance of at least four centimeters. Roentgenograms of the abdomen showed enormous distention of several loops of small intestine. The largest loop, occupying the lower abdomen, contained fluid as well as gas. The presence of free gas in the peritoneum was demonstrated by films taken in the dorsal decubitus, on one side, and upright views taken with the head up and the head down. Atresia of the ileum seemed the obvious diagnosis, and immediate operation was performed under local anesthesia. Whole blood was given via tibial bone marrow during the procedure. It was found that the enormously distended ileum ended in a blind loop which was fixed in the pelvis and had perforated. There was free gas and a moderate amount of greenish fluid in the peritoneal cavity. Distal to this point of atresia and between it and the ileocecal valve were two tiny segments of rudimentary bowel, each about one cm. in length by four mm. in diameter, each ending blindly but being connected by a delicate cord attached to the mesentery. The colon was intact and in normal position, being about five mm. in diameter except in the sigmoid region where it was about six or seven mm. in diameter. The greatly dis-

tended distal ileum had twisted upon itself in such a way as to produce a virtually closed loop approximately four cm. in diameter by ten cm. in length. This loop contained thick liquid material and gas, and the wall was almost gangrenous. The closed loop was resected, an anastomosis performed between the ileum and sigmoid colon, which was the only part of the colon large enough to function satisfactorily, and an ileostomy tube placed in the free distal end of the ileum. The infant took feedings well and passed stool from the rectum immediately following operation, and fluid balance was maintained by parenteral electrolyte solution and intramarrow transfusions of whole blood and plasma. Drainage from the ileostomy gradually became greater than from the rectum, and at the end of three weeks it was apparent that the patient was losing fluid more rapidly from the ileostomy than could be compensated for, in spite of the fact that feedings of five ounces were taken every four hours. Accordingly, at this time the ileostomy was broken down and the distal ileum anastomosed to the ascending colon, which by this time had increased in size until it was about one cm. in diameter. The infant began to improve after this procedure, but one week later died suddenly (at the age of four weeks) immediately following an intra-marrow plasma transfusion. The cause of the sudden death was not disclosed by necropsy.

* * *

In a somewhat similar case previously reported by the author⁵ eight points of atresia were found between the duodeno-jejunal junction and the ileocecal valve.

An occasional newborn infant will begin to vomit soon after birth, and present dehydration and abdominal distention, but the roentgenogram of the abdomen will immediately clear up the diagnosis. The gas pattern shows an even distribution throughout the small and large intestine, ruling out the possibility of atresia, and the baby is usually relieved by medical management.

ANOMALIES OF THE RECTUM AND ANUS

When the anal plate fails to rupture through before birth, imperforate anus results. This simple condition is readily corrected by passing a probe through the anal dimple; when meconium escapes the opening is dilated with the blades of a mosquito forceps until it can be dilated with the little finger tip. If, however, no meconium is obtained upon probing the imperforate anal plate, the problem is not so simple, and further investigation is necessitated. Examination of the vagina in the female or the urethra in the male for meconium will disclose the presence or absence of a recto-vaginal or recto-urethral fistula. If these are not present, the assumption is that the rectum has not descended to meet the ectodermal anal plate and occupies a position in the pelvis, which can usually be confirmed by roentgenogram within twenty-four hours of birth, as illustrated in the following case.

Illustrative Case No. 4.

A female newborn infant was found to have an imperforate anal plate, which upon probing produced no meconium. Roentgenogram taken with head down, twenty-four hours after birth, showed the gas shadow of the sigmoid colon ending blindly in the true pelvis. Operation was immediately performed under local anesthesia. Through a small midline anal incision, the fibers of the rudimentary anal sphincter were isolated and retracted. By gentle, blunt dissection the blind end of the rectum was found near the upper end of the vagina, was isolated and freed retroperitoneally until it could be drawn down to the anal skin. The rectum was then opened and sutured to the anal skin, following which the sphincter was reconstructed. The patient made rapid convalescence, and at the end of six months the anus was functioning in a normal manner.

* * *

Colostomy was formerly done on these babies at birth, but most of them died. The extra-peritoneal operation under local anaesthesia is simple, safe, and practically always successful.

HERNIATION INTO THE UMBILICAL CORD (OMPHALOCELE)

Congenital umbilical hernia may involve the presence of only a small peritoneal sac in the umbilical cord or, at the other extreme, an enormous sac containing practically all the abdominal viscera. In the latter case, there is concomitant marked deficiency of the abdominal wall. The simpler forms of omphalocele are easily corrected at birth by resection of the omphalomesenteric duct, with attached Meckel's diverticulum, resection of the sac, ligation of the umbilical vessels, and repair of the muscle defect. These procedures involve very little risk. The very large defects with hypoplasia of the abdominal muscles, however, are a serious threat to the life of the infant whether treated surgically or allowed to remain untreated. These sacs usually contain liver and spleen, as well as all the hollow viscera, and attempts to place the liver beneath the diaphragm usually produce serious cardiac and respiratory embarrassment. If, on the other hand no attempt is made to correct the condition a fatal outcome is inevitable. Closure of the defect with cutaneous and muscle flaps may save the baby's life.

ATRESIA OF THE BILIARY DUCTS

Icterus of the newborn infant is too common to be noteworthy, but when it persists after the first two weeks and when the stool is acholic, congenital atresia of the bile ducts must be suspected. As long as the infant's nutrition remains satisfactory, operative exploration may be delayed, since occasionally obstruction in the extrahepatic biliary system may be incomplete and will open up spontaneously. If the stool remains acholic for several weeks while there is deepening jaundice and a progressive

weight loss, further delay of operation is dangerous.

About one third of all the congenital atresias of the biliary system involve only the extra-hepatic system and are amenable to surgical correction. These usually involve atresia in the common hepatic duct or in the common bile duct. Associated with atresia in the hepatic duct there may be a patent cystic duct which empties directly into the duodenum. The remaining two thirds of the cases of biliary atresia involve all the extra-hepatic ducts and sometimes the intrahepatic system as well. A gallbladder is usually present and patent. This type of case is seldom treated successfully.^{6,7}

Illustrative Case No. 5.

A seven-month old female infant, since birth had been deeply jaundiced and had acholic stools. An attempt at surgical correction at one month of age had been unsuccessful, since no bile containing duct could be found. Her development and growth had obviously been retarded. The rounded edge of her liver was palpable four cms. below the costal margin. Her prothrombin time and plasma proteins were low and the albumin-globulin ratio was reversed. After careful preparation exploration was carried out under local and light ether anesthesia. The liver was large, olive green and had a finely granular surface. The gallbladder was present and patent, but the cystic, hepatic, and common bile ducts were solid cords with no lumen. Both hepatic cords were followed into the liver substance in the hope of finding bile containing ducts. No bile containing radicles were found in the left lobe, but on the right an epithelial-lined cavity about one cm. in diameter was encountered. Although this cavity seemed to contain no bile, a small rubber tube was sutured into the cavity and anastomosed to the duodenum. At the end of two weeks an occasional stool contained a trace of bile. At the end of two months, the stools contained bile on two days out of three, and the baby had gained nearly two pounds since operation. Jaundice was still present, however. Six months later all stools contained bile.

* * *

CONGENITAL HYPERTROPHIC PYLORIC STENOSIS

The symptomatology of pyloric stenosis in the infant is well known. Occurring predominantly in male infants who are normal at birth and during the first few weeks of life, vomiting begins usually during the third to sixth week, increasing in frequency until projectile vomiting occurs after almost every feeding. The infant passes progressively less stool and loses weight. Examination invariably shows active, visible peristalsis coursing from left to right over the upper abdomen, and a firm olive-shaped tumor is often palpable beneath the liver just to the right of the midline. In the presence of true stenosis, atropine does not improve the situation, and with it the stomach tends to dilate. Roentgenograms with ingested thin barium show blunting of the column of

barium in the antrum of the stomach, a long and very narrow pyloric canal, and vigorous peristaltic waves in the stomach which are able to force only a trickle of barium through the pylorus in the course of several hours.

Illustrative Case No. 6.

An unusually large and husky male infant was breast fed and developed normally for three weeks when he began to vomit. During the ensuing week vomiting increased in frequency, became projectile, stools became scanty, and he lost weight. He showed classical physical signs. Operative Fredet-Rammstedt pylorotomy was performed under local anesthesia. During the first day he was bottle fed hourly with small amounts of breast milk. On the next day he was again placed on breast feeding every four hours. He did not vomit again and gained rapidly.

* * *

INTUSSUSCEPTION

When the diagnosis is made promptly and the intussusception can be reduced readily at operation the mortality remains low and the converse is equally true.

Illustrative Case No. 7.

A six months old female infant became ill thirty-six hours before admission. Immediately following her morning feeding she screamed with pain and became pale, passed a little gas and a small amount of stool. She was seen by a physician who gave her medication. The pain continued with lessened severity, but the baby looked sick. Three hours later she vomited and seemed relieved for the balance of the day, although she was not interested in food. The next morning she again cried with pain and doubled up. She vomited several times during the day, and in the afternoon passed a little bloody mucus but no gas or stool. Her abdomen was distended and she was feverish and quieter. When admitted to the hospital her temperature was 39 degrees, C., and her white cell count 22,000. She was apathetic and looked ill. Her abdomen was markedly distended, and large loops of bowel could be seen lying transversely. On the right side of the abdomen could be felt an indefinite, sausage-shaped mass which was very tender. The rectum was empty and ballooned out. Antero-posterior and lateral roentgenograms of the abdomen showed a typical pattern of small intestinal obstruction. There was no gas in the colon. At operation an ileocecal intussusception was found, the intussusceptum being in a position just proximal to the hepatic flexure. The entire cecum and first part of the ascending colon were gangrenous. A rapid resection of the gangrenous bowel was performed, and in order to conserve operating time and trauma an end to end anastomosis was done between the ileum and the ascending colon. The patient went into delayed shock six hours after operation and died six hours later. Due to technical difficulties, blood transfusion was not given until shortly before death.

Delay in diagnosis and inadequate postoperative supportive therapy were jointly responsible for the death of the patient. Although the more generous use of whole blood and anti-

biotics have greatly improved the prognosis of bowel resections in infants during the past decade, the mortality is still high.

* * *

MECKEL'S DIVERTICULUM

Bleeding from ulceration in ectopic gastric mucosa in a Meckel's diverticulum is one of the commonest causes of massive intestinal hemorrhage in the infant. Perforation, peritonitis, and obstructive complications are not uncommon, either with or without hemorrhage. The diagnosis must often be made by exclusion, since the diverticulum is seldom clearly revealed by roentgenogram.

Illustrative Case No. 8.

An exceptionally well-developed and nourished one-year old infant was admitted to the hospital with a history of several bouts of severe melena during the previous week. His skin showed waxy pallor; he was listless and fretful. His abdomen was not distended, but there was slight tenderness about the umbilicus. His temperature was 38 degrees C., his red cell count 2,000,000, hemoglobin 7 grams, and white cell count 15,000. According to the history, the patient had had an attack of abdominal pain, vomiting, fever, and some rectal bleeding one month prior to the present attack. His stool at the time of this admission showed occult but no macroscopic blood. After several blood transfusions, barium studies of the gastrointestinal tract were made. The entire study was negative except for the finding of a barium filled pocket in the ileum which was tender to palpation. This was interpreted as being a Meckel's diverticulum. At operation, a loop of ileum was found plastered together with inflammatory adhesions 20 cms. from the ileocecal valve. In the center of this mass was a Meckel's diverticulum which had perforated into its mesentery. In the wall of the diverticulum was an ulcer at the base of which was an artery covered with clot. Presence of ectopic gastric mucosa in the diverticulum was demonstrated by microscopic section. The involved loop of ileum was resected and an end to end anastomosis performed. The baby made a rapid and uncomplicated convalescence.

* * *

SUPPORTIVE THERAPY IN SURGERY OF INFANCY

The chief factors which make surgery of infancy hazardous are: (1) Difficulties in diagnosis; (2) technical difficulties in operating upon small patients; (3) relative intolerance of infants to shock, blood loss, fluid loss, and infection. Successful surgery upon infants, therefore depends upon: Early diagnosis; meticulous surgical technic maintenance of fluid, protein and nutritional balance and blood volume; and the judicious use of antibiotics.

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Author's Note: The author is indebted to members of the Pediatric Staff of St. Luke's Hospital for their diagnostic acumen and their management of some of the cases mentioned.

Penicillin in Dermatology

The status of penicillin in the treatment of cutaneous disorders, including syphilis, is in a constant state of flux, due to variations in the drug itself and even in the lots distributed by a single drug house, as well as due to the increasing reports of new studies.

1. Reports generally agree on the successful treatment with penicillin of abscess, actinomycosis, anthrax, carbuncles, cellulitis, coccogenic sycosis, ecthyma, erysipelas, erysipeloid of Rosenbach, folliculitis, furunculosis, hidradenitis suppurativa infectious eczematoid dermatitis, impetigo, keratoderma blennorrhagicum, paronychia, pyoderma gangrenosum, syphilis, ulcers (infected), Vincent's angina, yaws and secondary infections in mycosis fungoides, kerion and dermatitis venenata.

2. Unsatisfactory results have followed treatment with penicillin of acne vulgaris, chancroid, dermatomycosis, eczema, granuloma inguinale and lymphogranuloma venereum lupus erythematosus, pemphigus vulgaris, and psoriasis.

3. Outstanding advantages in the treatment of certain diseases are: absence of drug mortality, fewer adverse reactions than with metal therapy and some other drugs, vastly quicker results in certain treatments, fewer reports of sensitization than with many popular drugs, disability period greatly reduced below that of other treatment of local infections, and absence of deformity in certain cases formerly requiring surgery.

4. Regional injection method with penicillin in beeswax and peanut oil (POB) has proven successful by the writer in the treatment of carbunculosis.

5. Paralleling certain pioneer hospital and clinical studies for more than two years, the experience of this writer with penicillin in beeswax and peanut oil, in the treatment of certain cutaneous diseases, has been, even when limited to office practice, very satisfactory.—Norbert C. Barwasse, M.D., Moline, Illinois *The Illinois Medical Journal*, Vol. 93, No. 1, January, 1948.

Chemotherapy in Infants and Children

II. Penicillin

JAMES G. KRAMER, M. D.

LEMING, in 1929, first noted the toxic effects of the mold *penicillium notatum*.

Eleven years later, Florey reported on the therapeutic application of penicillin or the extract of this mold. During the past five years we have come to look upon penicillin as an indispensable part of our medical armamentarium. It has one big advantage over the sulfonamides in that it retains its antibacterial action in the presence of pus and tissue breakdown products. Chart II gives a list of the organisms susceptible to penicillin.

CHART II

Streptococcus Hemolyticus	B. Diphtheria
Streptococcus Viridans	Actinomyces
Pneumococcus	Clostridium Botulinum
Staphylococcus	Clostridium Welchii
Meningococcus	Clostridium Septicum
Micrococcus group	Clostridium Tetani
Borrelia Novji (Relapsing fever)	Treponema Pallidum
Leptospira Icterohaemorrhagiae (Infectious jaundice)	

It will be noted that penicillin can be used against the same organisms as the sulfonamides with the exception of some of the gram negative group, commonly found in urinary infections. There are, however, notable additions to the sulfa list, such as streptococcus viridans and the treponema pallidum. It is also much more effective against staphylococci. Penicillin is nontoxic for animals in concentrations one hundred times greater than required to inhibit bacteria. It has little or no action on bacteria in solutions where growth is prevented by lack of nutrients. However under conditions which normally allow bacterial growth, penicillin causes their death. This failure to act on nonproliferating organisms is not explained at the present time. Penicillin in all probability, like the sulfonamides, interferes with the normal metabolism of the proliferatory bacteria and thus produces death. The bactericidal action of penicillin requires a definite period of exposure of the organisms to the drug and this period increases with decreasing concentrations of penicillin. Adequate concentrations of penicillin will take several hours or longer to accomplish bacteriostasis.

METHOD OF ADMINISTRATION

Penicillin has been administered by every available route. With the intravenous route the drip

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must be continuous to keep an adequate blood level. With the intramuscular and the subcutaneous injections the peak blood levels are reached within 30 minutes followed by a rapid fall. Fleming¹ has shown that it will take 20,000 units dosage intramuscularly in adults to produce a bacteriostatic concentration of penicillin in the blood plasma after a three-hour interval. Without a doubt the continuous intravenous or intramuscular administration is the best for severe infections. In infants and young children the technical difficulties almost make the prolonged drip impossible, so intramuscular or subcutaneous injections are to be preferred. In our experience there is no more pain from the subcutaneous injections than from the intramuscular ones. The new purified products now on the market cause much less discomfort than the earlier drug. Again, the addition of procaine to the solution when it is mixed will help prevent undue discomfort.

DOSAGE OF PENICILLIN

The amounts of penicillin to be used vary with the type and severity of the infection as well as the response to treatment. The necessity for large doses cannot be stressed enough because the bacteria must be overwhelmed from the start. Increased resistance to penicillin can and does develop at times but if the dosage is adequate from the start the results should be good. There is evidence that resistance may be related to the production of penicillinase, a penicillin destroying enzyme first isolated from gram negative bacilli by Abraham and Chain. For infants a dose range of 10,000 to 20,000 units and for children 20,000 to 40,000 units every three hours by intramuscular or subcutaneous injection should prove sufficient for ordinary infections. The rapid absorption and excretion of penicillin stimulated a search for methods to either diminish the rate of absorption or retard excretion. Aluminum penicillin as well as

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penicillin dissolved in mixtures of wax and oil did slow absorption. However, resulting blood levels were erratic and one could not depend upon therapeutic levels at all times. The site of the oil wax injections were usually painful and many abscesses developed. A number of drugs were used to retard excretion, notably Diodrast, Phenol red, Para-aminohippuric acid, Hippuran and Benzoic acid. Peculiarly, these drugs were excreted in preference to penicillin so that the plasma concentration of the latter remained elevated.² These methods should not be used until we are sure that they are safe and give consistent results.

ORAL ADMINISTRATION OF PENICILLIN

Oral administration of penicillin naturally is most desirable. However, it was early learned that the hydrochloric acid in the gastric juice destroyed penicillin. The gastric juice in infancy is low in acidity, both total and free. Infections also materially reduce the amount of free hydrochloric acid in the gastric juice. When giving penicillin by mouth the dosage should be about five times the amount given intramuscularly. This should permit sufficient amounts to escape the hydrochloric acid. Various attempts have been made to add anti-acids, alkalies, oils, and buffer salts to the penicillin to neutralize the hydrochloric acid and favor a higher absorption of penicillin. At present no one method seems better than the other. Penicillin dissolved in plain water seems to give as high plasma levels as when buffers or alkalies are added. The giving of penicillin on an empty stomach does favor absorption and limiting the diet to clear fluids during the period of administration is helpful. Oral administration of penicillin is complicated by the fact that the presence of penicillin in the small bowel stimulates some bacteria normally present there to manufacture penicillinase, which actively destroys penicillin. This process may be impeded or stopped by the simultaneous administration of sulfaguanidine. Buchanan⁸ and others have reported good results with oral penicillin in prematures, newborns, and young infants. They stress the fact that the kidneys of the very young infant, especially the premature infant, are relatively inefficient. Probably the adult type of function is not acquired until the end of the first year of life. This may be a factor in the production of high penicillin levels of the blood in young infants. The most one can say at present for oral administration of penicillin in older children is that the results are very erratic and its use should be limited to those cases that cannot be given the drug with the needle.

AEROSOL ADMINISTRATION OF PENICILLIN

The inhalation method of administering penicillin has been particularly effective in some

types of infection of the respiratory tract, notably laryngotracheitis, capillary pneumonia, and bronchiectasis. An aerosol generator can discharge a mist of penicillin solution into an oxygen tent, using 80,000 units per hour. A continuous or intermittent flow may be used. If the patient is out of the oxygen tent a mask or nebulizer may be used. Oxygen at the rate of 4 to 7 litres per minute is forced through a penicillin solution, producing a fine mist which is inhaled by the patient for periods of five to ten minutes every one to four hours as desired. It is usual to use 10,000 units of penicillin dissolved in one half distilled water and one half peppermint water to obscure the musty odor of the drug.⁴ The results with this method of treatment have been so encouraging that when certain mechanical difficulties with the apparatus have been overcome it will be more popular.

INTRATHECAL PENICILLIN

With the usual parenteral doses of penicillin little if any of the drug appears in the spinal fluid either in normal patients or those with infections in the subarachnoid space. Therefore in infections of the meninges, penicillin should be given intraspinally, 10,000 to 20,000 units may be injected in the strength of 1,000 units per cc. of normal saline. This dosage will permit adequate concentration of penicillin in the spinal fluid for a 24-hour period. Stronger solutions may produce local irritation of the nervous system. No more solution should be injected into the subarachnoid space than the volume of spinal fluid withdrawn.

LOCAL USE EXTERNALLY AND IN BODY CAVITIES

Penicillin will diffuse into the pleural spaces, pericardial sac, and joint cavities up to about fifty per cent of the blood level. Because this level is probably inadequate, 20,000 to 50,000 units should be injected daily into cavities infected with susceptible organisms.

The local use of penicillin has advantages and disadvantages. In gonorrheal ophthalmitis the local instillation of penicillin solutions in saline, 1000 units per cc., is very effective but systemic treatment should be used in addition. In minor infections of the conjunctiva it is of great help as is the penicillin ophthalmic ointment. Many cases do develop local sensitivity that demands the discontinuation of treatment. In Vincent's gingivitis penicillin troches are of benefit when used almost continuously. Penicillin solutions or ointments have been used for pyogenic skin infections both for treatment and prophylaxis in the newborn. There are selective cases where it is indicated and effective but it should not be used routinely. Pyogenic infections of the skin respond to systemic administration of penicillin.

Penicillin has come into great vogue for the treatment of rhinitis and infections of the nose

and throat. A saline solution containing 1,000 units of penicillin per cc. is usually dropped or sprayed into the nose. Considering how rapidly a solution in the nose is removed by nasal secretions and ciliary action it is difficult to imagine how the penicillin can remain in contact with the offending organisms long enough to be bacteriostatic. Certainly it has no curative or healing action on the mucous membranes. Many cases treated with penicillin nose drops develop the pale, baggy, swollen, mucous membranes so typical of allergy that one wonders if more harm is being done than good. In chronic nasal sinus infections the Proetz displacement treatment with weak penicillin solutions might eventually prove to be helpful.

OTHER USES OF PENICILLIN

Because of the high penicillin content of the urine after normal dosage this drug is ideal for urinary tract infections with susceptible organisms.

Diphtheria bacilli are sensitive to penicillin and the drug should be used in the severe cases of diphtheria we have been encountering lately. Penicillin is not a substitute for antitoxin; the latter is of paramount importance. In diphtheria carriers both local and systemic use of penicillin is indicated.

Penicillin is the only drug that is effective against subacute bacterial endocarditis caused by the *Streptococcus viridans*. In this condition large doses over a long period of time is indicated.

Penicillin is the most effective drug we have for congenital and acquired syphilis in infants and children. Reports are all in agreement that symptoms and signs are cleared quickly and the blood tests change to negative in 6 to 18 months with very few reversals.⁵ The usual doses of penicillin should be given continuously every three hours for at least fifteen days. Until we are sure that the results are going to be permanent, one should start the regular bismuth and arsenic continuous routine after the penicillin treatment.

TOXICITY

Penicillin can be very toxic at times. It can act as a direct toxin or primary irritant or produce antigenic and allergic reactions.⁶ A list of toxic reactions gives one an idea of the extent of the process.

Skin rashes, erythemas, urticaria, and angio-neurotic edema.

General toxic symptoms, malaise, headache, chills, fever, nausea, vomiting, and abdominal cramps.

Respiratory system, acute dyspnea, pulmonary edema, acute syncope.

Nervous system, dizziness, vertigo, convulsions,

loss of consciousness, euphoria, agitation, confusion or depression.

Genito-urinary system, hematuria, pseudo-albuminuria, tingling in testes, and epididymitis.

Drug or serum sickness like syndromes.

When toxic symptoms from penicillin occur the drug should be withdrawn and symptomatic treatment given. No permanent damage or injury from penicillin has been noted.

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Treatment of Migraine

In the treatment of migraine one must treat the condition not as a clinical entity with one cause and one specific cure, but as a clinical syndrome. Although a person with migraine may have a certain type of personality, also a hereditary background, minor physical disturbances, overfatigue, and a life situation that is full of stress and strain are necessary to produce the migraine situation. In the treatment of a patient with migraine headaches three procedures must be carried out. First, one must treat the headaches per se, reduce them to a minimum, and thereby improve the patient's general well-being. Secondly, one must correct such physical abnormalities as allergic sensitivity, endocrine disturbances, errors of refraction, and hypothyroid conditions if they are present. Diseased tonsils, abscessed teeth, malnutrition, obesity, and any organic disease should be corrected. Thirdly, one must have a complete understanding of the patient's family and home environment and should attempt to adjust the patient's way of life so that he will fit his type of personality into his home in such a way as to relieve as much as possible any emotional strain, overfatigue, and unhappiness.

In the treatment of the headaches the one drug that seems to be the most efficacious in relieving individual migraine attacks is ergotamine tartrate (trade name "Gynergen"). This drug does not cure migraine but it does relieve the headaches and, if used properly, it decreases their frequency and improves the patient's morale. —Edith E. Nicholls, M. D., Danville, Pa., Penna. *Medical Journal*, Vol. 51, No. 4, January, 1948.

Squamous Cell Carcinoma Following Prolonged Use of Arsenic. Case Report*

J. W. ROBERTSON, M.D., and K. W. CLEMENT, M.D.

IN 1888, Hutchinson¹ reported six cases of superficial epithelioma in which he inferred that arsenic had been the underlying cause. Following work by Osbourne,² Montgomery,³ and Wile,⁴ the carcinogenic effects of arsenic have been more scientifically elaborated. One of Hutchinson's cases closely resembled the one herein reported—a carcinoma of the right palm which was fatal following widespread metastases. In every case except one arsenic was known to have been used. In the one doubtful case, it was most probably prescribed as the patient—like the others—had been treated for psoriasis. Since 1888, interest in this subject has been sporadic, with major contributions in 1925 by Osbourne² and in 1941 by Montgomery



Figure 1—This photograph shows the generalized cutaneous mottling and fungating cancerous mass on the right fifth finger.

and Waisman.⁵ Caution in the use of Fowler's solution, and suspicion of any significant changes in the keratotic lesions it may produce, are emphasized by the report of this case—a classical picture of arsenical carcinogenesis

CASE REPORT

W. M., a 48-year old white male, was first admitted to Cleveland City Hospital in June, 1945. At that time he complained of an indolent "sore" on his right little finger. The patient had been treated for psoriasis for 42 years. For six years prior to admission, he had been taking solution of potassium arsenite (Fowler's solution) in increasingly larger doses until he consumed eighteen drops a day. Two years before admission horny, wart-like growths appeared on the dorsum of his hands, fingers, and soles. These were severe enough to incapacitate

*From the Surgical Service of Cleveland City Hospital. Case for discussion at Clinical-Pathological Conference, May 3, 1946. Submitted September 5, 1947.

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the patient. Eight months before admission the patient struck one of these growths overlying the distal joint of the right little finger. Here the indolent sore developed in a site free from previous psoriasis. Silver nitrate cauterization by local physician proved futile.

Physical examination revealed a well-developed, well-nourished male with a normal temperature, pulse, and a blood pressure of 140 systolic and 78 diastolic. The skin was superficially scaly with generalized mottled pigmentation. This was accentuated in the small of the back, lower abdomen, popliteal fossa and pubic area. The soles of both feet were covered with thick horny excrescences, almost 1.5 cm. thick and tender on pressure. Although there were other areas of hyperkeratosis, the distal portion of both extremities had the greatest amount. On the dorsum of the little finger, there was a foul smelling, friable granulomatous lesion of spherical shape. It was approximately 4-5 cm. in diameter, and overlay the distal joint, hiding the finger tip from view.

The examinations of the urine and blood were normal. X-ray examination on June 6, 1945, of the chest and head were negative. Biopsies of the skin and tumor on June 10, 1945, revealed a microscopic picture consistent with arsenical keratosis and well-differentiated squamous cell carcinoma. Metastatic carcinoma was found in an axillary lymph node removed for examination on August 6, 1945.

Amputation of the right little finger was performed on June 14, 1945, with a block dissection of the right axilla on August 1, 1945. The axillary wound developed fluid which was drained. Persistent sinus tracts were later excised and the patient discharged to the out-patient department for follow-up.

He was readmitted to the surgical service in March, 1946, complaining of a burning pain in his right arm. On this admission his general condition was unaltered from his previous one.

There was considerable induration and moderate tenderness beneath the surgical scar in the right axilla. There were no nodes palpable in the axilla but the right medial epitrochlear was palpable. No evidence of recurrence was seen.



Figure 2—This photograph demonstrates the extreme hyperkeratinization of the soles of the feet, with many cornified warts which had to be removed with a scalpel.

in the well-healed amputation stump. A fluctuant abscess developed just above the anterior axillary fold. This was incised and drained, healing with little difficulty. An X-ray of the chest taken on March 23, 1946, demonstrated a moderate amount of pleural effusion on the left without evidence of any definite pulmonary infiltration. In an effort to evaluate the worth of radical disarticulation of the right arm, thoracoscopy was done, revealing no metastatic tumor.

On April 2, 1946, exploration of the axilla revealed metastatic carcinoma lying beneath the pectoralis muscles and the chest wall. Recommendation of further surgery was refused by the patient. On the 20th of April, 1946, the patient began bleeding from the axilla and despite transfusions and pressure dressings this continued. On April 25 an exsanguinating hemorrhage resulted in death.

AUTOPSY FINDINGS

At postmortem examination the cutaneous lesions were as described at previous physical examination. A microscopic section of the skin revealed marked keratinization and acanthosis with vacuolation of cells in the epidermis. There were numerous epithelial giant cells and moderate lymphocytic infiltration of the dermis. In one section there were isolated fragments of squamous cells showing prickling and pearl formation.

Dissection of the right axilla confirmed the findings at operation of metastatic carcinoma, which had eroded the axillary artery and accounted for the patient's death. There were no other metastases found.

COMMENT

It is not the purpose of the authors, nor within the scope of this report to review completely in detail the literature, nor outline the possible therapy. However, in the light of recently published reports by Pack⁶ on radical amputations in malignant growths of the extremities, and in as much as this patient had positive nodes, an interscapulothoracic exarticulation on his first admission would have afforded the patient the best prognosis.

We may conclude that prolonged use of arsenic gives rise to keratotic lesions, upon which malignant change is engrafted with facility. The case herein reported is an example of such.

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Industrial Dermatoses

History.—In no field of medicine is the taking of a careful history and an acquaintance with industrial chemistry more essential than in the care of industrial employees.

(a) Was first appearance a reasonable period after beginning present work?

(b) Did eruption first appear over the unprotected areas?

(c) Have other fellow workers been similarly affected or does medical literature report other cases from similar exposure?

(d) Does removal of worker from present environment for a period of not less than one or two weeks improve his condition?

(e) What other possible contacts may occur at home or during their off hours?

* * *

Examination.—(a) Examine the entire skin surface of the stripped body including feet for fungus infection and the oral mucous membranes for possible evidence of nonindustrial diseases.

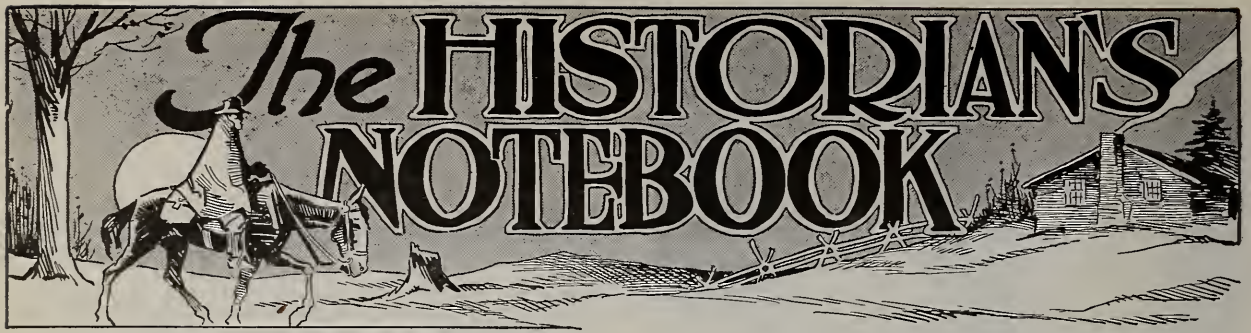
(b) Note character of primary or first type of lesion, location, spread and changes which may have occurred from treatment.

(c) Is eruption worse over areas where contaminated or poorly laundered work clothes and perspiration may have been contributing factors?

(d) What water softeners or bleaching chemicals have been used in laundering of work clothing?

(e) Is eruption of a bacterial type and does it cause any elevation of temperature?

(f) Finally, make patch tests with suspected irritant moistened preferably with perspiration. —E. P. Monahan, M. D., Kansas City, The Journal of the Missouri State Medical Association, Volume 45, Number 2, February, 1948.



Noah Worcester, M. D.—The Forgotten Pioneer

WILLARD L. MARMELZAT, M. D.

SELDOM has Dame Fortune been less prodigal with her bounties than in the case of a young Ohio doctor, the one hundredth anniversary of whose death has passed virtually unnoticed. It is difficult to believe that the far-sighted physician who first introduced the methods of Laennec to the West, who was the best trained physician of his day in auscultation and percussion, the first professor of physical diagnosis in America, and the author of the first textbook on dermatology in this country, remains so little known to the medical profession.

Noah Worcester was born on July 29, 1812, at Thornton, New Hampshire. After completing his preliminary education at Exeter Academy, in 1829 he matriculated to Harvard at the age of 16. In his freshman year his father, a school-teacher who had hitherto been in prosperous circumstances, lost his fortune. The young Worcester then ingeniously worked his way through college by taking charge of a school at Gloucester during the Winter months and additionally giving courses of lectures on chemistry and natural philosophy to the adult citizens of Gloucester. Graduating from college in 1832, at the age of 20, he became the principal of an academy of some eminence in Peacham, Vermont. The ensuing four years saw the young man act not only as principal, teacher, and lecturer but also commence the study of medicine by reading textbooks. After turning down a would-be benefactor's offer to subsidize his education if he would pursue the study of law, he left his teaching position and in the Fall of 1836 entered the medical department of Dartmouth College. The versatility of the young medical student manifested itself again for he supported himself by teaching French at the college and by holding classes in Italian for the adult citizens

of Hanover. In 1838, Worcester received his M. D. degree and became a partner of Dr. Reuben B. Mussey, the Dean of the medical school. When in the Fall of that year Mussey was invited to the chair of surgery at the Medi-

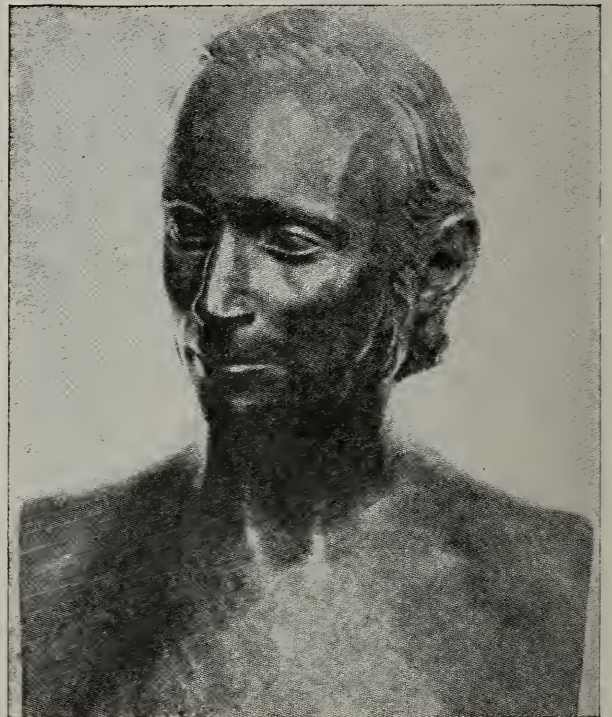


Figure 1. Bust of Noah Worcester.

cal College of Ohio in Cincinnati, Worcester accompanied him.

In his new environment the young doctor quickly acclimated himself developing a busy practice but continuing to devote himself to studying the newer treatises and furthering his medical knowledge. He must have fared well for in 1841, but three years later, he put into action what was evidently a long-cherished plan—a European trip to further his knowledge of

pathology and learn the new techniques of physical diagnosis.

When a student, Worcester had resolved "to put himself in the front rank of his profession". Once in Paris, this he assiduously set out to accomplish. From "early dawn till noon of night" he applied himself rigorously, observing thousands of cases of every variety, watching "almost all the operations included in the surgeons art", attending various autopsies which were "so frequent as to constitute Paris the finest pathological school in the world". From the adroit fingers and willing lips of the masters themselves he absorbed their knowledge of the auscultation and percussion methods. His interest in diseases of the skin became aroused and he took the "most comprehensive course of instruction" in dermatology at the famed L'Hôpital St. Louis. When the young American doctor took leave of Paris in October, 1841, he had obtained in his eight months' pilgrimage, medical training equaled by few of his countrymen.

FAILING HEALTH

Upon his return to America, Worcester married Miss Jane Shedd, his fiancée from medical-school days, and shortly thereafter returned to Cincinnati where he quickly established a reputation as an authority on diseases of the chest and skin. Personal misfortune struck when his wife, who had first become ill a few weeks after marriage, died within a year of "consumption". Shortly thereafter Worcester, then but 29 years of age, developed the signs and symptoms of pulmonary tuberculosis. Delamater¹ offers this intriguing comment: "He (Worcester) had embraced peculiar views in regard to consumption, believing it to be contagious. In his long and anxious watch over his wife he always believed he had contracted the same disease which exhibited evident indications of its presence in his system within a very short time after her decease."

In the schoolyear 1842-1843, despite failing health, Worcester became Professor of Physical Diagnosis and General Pathology at the Medical College of Ohio in Cincinnati. Here he enjoyed unusual popularity as a lecturer. Feeling his days were numbered, he resigned his academic position after one year and left on a journey of several months to improve his health. His condition evidently became better for upon his return to Ohio when he was offered the chair of General Pathology, Physical Diagnosis and Diseases of the Skin at the new Medical Department of Western Reserve College in Cleveland, he accepted. This school was then being organized by Dr. John Delamater who had known Worcester both at Dartmouth and Cincinnati. In the Winters of 1843-44 and 1844-45, Worcester taught courses in physical diagnosis and

diseases of the skin, plus an abbreviated pathology course.

He drove himself relentlessly. When he had to shorten the time of the pathology course he lectured three times per day so as to completely cover the material. When the medical school was

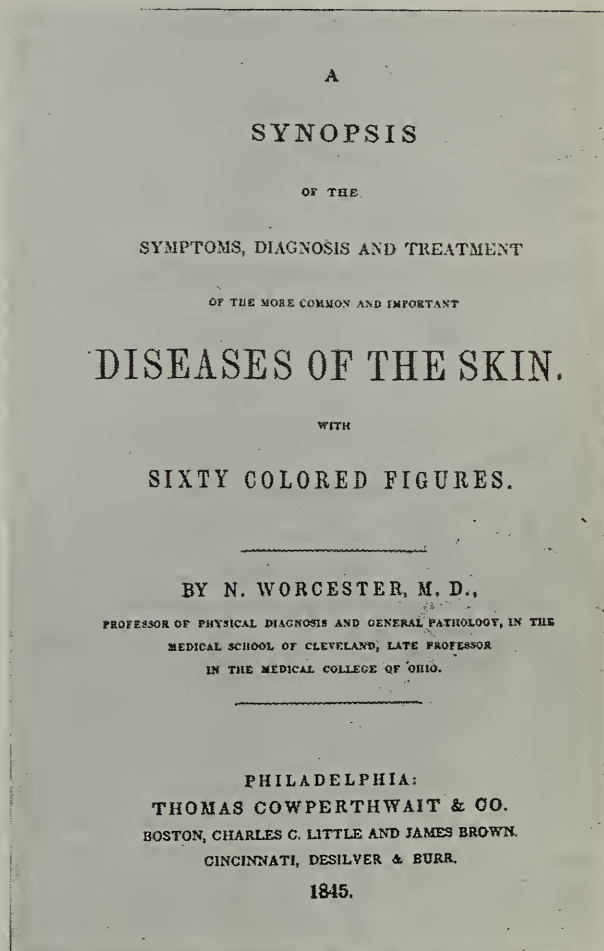


Figure 2. Title page of the first American dermatology textbook.

not in session in Cleveland he returned to Cincinnati and continued his large practice there during the remainder of the year. Worcester's health became progressively worse and in the Fall of 1845 he traveled to Cleveland to meet with the class for a single hour in which he informed his medical students he could not teach that year. This marked Worcester's last academic appearance although he was listed as a faculty member at Western Reserve until 1847 in which year he died in Cincinnati. Much sought after as a consultant to the day of his death, Worcester practiced in Cincinnati to the very end. The life cycle of a pioneer physician lasting but 35 well-spent years was completed—Noah Worcester had died in harness.

II.

In 1845, there was published in Philadelphia the first American dermatological textbook, *Diseases of the Skin* by N. Worcester, M. D.² In

the preface the author remarks upon the long need for a "concise and accurate treatise in our language with suitable illustrations at a price within the reach of all". The book itself is of pleasing format, a large octavo 6 1/4 x 9 5/8 inches in size. There are 292 pages comprising a preface, introduction and text, and in the rear a ten-page formulary and eight pages containing some 62 colored illustrations with explanatory notes. The printing is well done and the illustrations are excellent. These dermochromes must have doubtlessly been prepared in Europe. There is no way of now knowing what the original selling price of the book actually was.

Worcester's style is straightforward and clear. Although he acknowledges his intellectual debt to his European predecessors and contemporaries, he clearly shows grasp and familiarity at first hand with the various cutaneous conditions he considers. There are many illuminating observations and thoughts in this book which have a surprisingly modern ring. For example:

TEACHER AND LECTURER

With regard to the teaching of dermatology the author complains, "When we consider the variety and importance of cutaneous diseases it is difficult to explain the neglect with which they are treated by practicing physicians generally . . . they scarcely form a part of the professional education of our students . . . in many of our medical institutions not a single lecture is given on the nature, classification, and treatment of this interesting group of diseases."

Decades before clinical case history taking was to be formally introduced we find Worcester stressing the modern concept of the value of history taking, "Where you cannot satisfy yourself . . . as to the elementary form of the lesion . . . try to learn from the patient or friends the appearance of the disease at first, as whether the vesicles were from the very first filled with a clear, limpid, or with an opaque, yellow fluid, etc."

Present-day physicians who might erroneously believe in the newness of the concept of a psychosomatic relationship between the emotions and so-called "neurodermatoses" might well note the passage which reads, "The effect of violent passions, long continued grief, despair, anxiety, etc., is well established as conducing to the development of this class of affections (dermatological). The well authenticated cases recorded by authors arising from this cause are very numerous . . ."

A half century before the foundations of scientific allergy were to be laid we find this sound observation from Worcester, "Instances in which some affection of the skin is excited by an article of diet which is wholesome to most individuals

are very numerous, and indeed it is usually by this class of diseases that such idiosyncrasies are manifested."

The author clearly points out the causative and supportive roles played by "the want of public baths and proper attention to cleanliness", by heredity, the natural texture of the skin, the occupation of the individual and his temperament. He is well aware of the climatic influences and seasonal incidences as related to skin diseases.

Throughout the book there can be discerned the beneficial influence of his general medical and pathology background upon his dermatological concepts. For example we note, "The great reason that the treatment of cutaneous diseases has generally been attended with so little success is that we prescribe for them too empirically, and do not pay sufficient attention either to the pathology or the stage of the eruption. The same general principle should govern us here, as in the treatment of all other diseases."

Thus we take leave of an unusual medical textbook, the more remarkable in that it was conceived and written while the author was waging a losing struggle against tuberculosis. Perhaps paradoxically because both book and author were thirty years ahead of their time they were quickly forgotten. It was thirty years before another dermatological textbook was published in the United States. It is to be hoped that when the medical history of Ohio, the old "West" and our country is written the indomitable pioneer spirit of Dr. Noah Worcester will have a lasting niche.

BIBLIOGRAPHY

1. An Introductory Address on the Life and Character of the Late Prof. Noah Worcester, M. D., Medical Faculty of the Western Reserve College, Cleveland, Nov. 3, 1847, delivered by Jacob J. Delamater, M. D., Prof. of Anat. and Phys. published by the Medical Class, Cleveland, Younglove's Steam Presses, 1847.

This is a pamphlet which was published at the request of Worcester's students as a tribute to the esteem with which he was held by them. This address is thought to be the only known primary source of the details of Worcester's life. At present there are but two known copies of this pamphlet in existence.

2. The copy used for this study is in the William T. Corlett collection of the Allen Memorial Library in Cleveland.

Author's Note: I wish to acknowledge my gratitude to Miss Ada Floyd, Librarian, and the staff of the Allen Memorial Library for making available to me these two exceedingly rare and valuable medico-historical documents.

Cincinnati may be able to claim credit for having been the first American city to make tuberculosis a "reportable" disease. The distinction now is claimed by both Boston and St. Louis . . . In the annual report of the (Cincinnati) Health Department for 1897 is a copy of resolutions adopted by the Board of Health requiring physicians to report all cases of tuberculosis. This action is believed to antedate similar action in Boston and St. Louis. Ohio Pub. Health, Oct., 1947.

Resumé of Important Business Transacted at Cleveland Midyear Meeting of A.M.A. and Allied Agencies

THE House of Delegates of the American Medical Association, meeting in interim session January 5 and 6, at the Statler Hotel in Cleveland, selected Dr. Archer C. Sudan, of Kremmling, Colorado, as the first recipient of the annual A.M.A. gold medal award to "The General Practitioner of the Year".

Dr. Sudan has been practicing medicine in the mountain village of Kremmling, population 567, for 21 years, and is past-president of the Colorado State Medical Society.

Registration for the interim session totaled 4,230. This figure included 1,896 Fellows; and 2,334 interns, medical students, residents, industrial health physicians, and nurses.

OTHER MEETINGS HELD

Other activities connected with the interim session included the Eighth Annual Congress on Industrial Health, January 5 and 6, at the Cleveland Public Auditorium; The Second National Conference of County Medical Society Officers, January 6, at the Statler Hotel; a two-day scientific meeting for general practitioners, with scientific and technical exhibits, January 7 and 8, at the Cleveland Public Auditorium; and the Midwest Regional Conference on Medical Service, January 4, at the Cleveland Hotel.

Delegates representing the Ohio State Medical Association were Dr. Frank M. Wiseley, Findlay; Dr. William M. Skipp, Youngstown; Dr. L. Howard Schriver, Cincinnati; Dr. C. C. Sherburne, Columbus; Dr. Edgar P. McNamee, Cleveland; Dr. George A. Woodhouse, Pleasant Hill; and Dr. Carl A. Lincke, Carrollton.

During the session Dr. McNamee served as chairman of the Reference Committee on Miscellaneous Business, and Drs. Sherburne and Lincke served on the Reference Committees on Reports of Officers and on Credentials, respectively.

In accordance with one of the resolutions adopted by the House of Delegates, Fellowship dues have been advanced from \$8 to \$12, retroactive to January 1, 1948. The subscription price of *The Journal of the American Medical Association*, was likewise increased to \$12.

RESOLUTION ON INTERN PLACEMENT

Acting on a resolution concerning the distribution of interns, presented by Dr. McNamee in behalf of the Ohio Delegation, together with a similar resolution introduced from another state, the House of Delegates instructed the Speaker to appoint a special committee on in-

tern placement, consisting of five members, including two general practitioners, to:

- a. Study the supply and distribution of interns with particular emphasis on furthering interest in general practice.
- b. Cooperate with the Council on Medical Education and Hospitals and other agencies to arrive at a method of securing better distribution.
- c. Present a report of findings at the annual session of the A.M.A., June 21-25, in Chicago.

BOOST FOR PREPAYMENT PLANS

The House of Delegates also:

1. Reinstructed the Council on Medical Service to "continue to correlate and extend voluntary prepayment medical care plans in all phases as rapidly as possible throughout the U.S., to cover as large a percentage of the population as possible, particularly the low income group, in the shortest possible time".
2. Commended the Subcommittee on Expenditures of the House of Representatives of Congress for its action in exposing the activities of certain Federal employees engaged in lobbying for compulsory health insurance.
3. Requested the Board of Trustees to appoint a committee to study the various resolutions concerning "Hospitals and the Practice of Medicine", as previously passed by the House, and to arrange conferences with the hospital associations and the various specialist societies in order to work out a solution to the problem.

STATUS OF TEN-POINT PROGRAM

4. Heard a report from the Board of Trustees which outlined the progress toward accomplishment of the objectives of the Ten-Point National Health Program of the A.M.A., and contained recommendations for certain additional activities.
5. Recommended that the A.M.A. further, when indicated, the activation and support of measures designed to make case finding of pulmonary tuberculosis by chest X-rays as widespread as possible.
6. Amended and adopted the report of a Committee to Expedite Work of the House of Delegates. The effect of this action was to revamp the order of business, with separate orders for interim and annual sessions; eliminate the presentation of "distinguished guests" for addresses before the House; require that new business be

introduced at the first session of the House except by a majority acceptance on Wednesday and unanimous vote on Thursday; provide for nomination of reference committees two months before the session and publication thereof one month previously; and to rule that the Reference Committee on Executive Session consider all matters referred to it in executive session, and report to the House only when the latter is in executive session.

CONFERENCE COMMITTEE APPROVED

7. Approved a recommendation that the A.M.A. cooperate with the American Hospital Association and the American Nurses Association in the creation of a permanent conference committee of 15 members, five to be named by the Board of Trustees of the A.M.A. to study common problems related to nursing.

8. Endorsed the National Multiple Sclerosis Society and its program of education of the public and of undertaking investigations in this field in qualified hospitals.

9. Continued "approval in principle" of a previous resolution in regard to establishment of blood banks by the American Red Cross, provided that responsibility for technical details rest on properly trained personnel under the control of local or state medical societies.

10. Commended the work of the Committee on Rural Medical Service and recommended its continued expansion.

11. Adopted a resolution that Congress and the U.S.P.H.S. be requested to require adequate and reliable physical examination, including chest X-ray of immigrants, prior to and as a condition of entry.

12. Approved the suggestion of the Speaker that proposed revisions of both Constitution and By-Laws of the A.M.A. be considered at the annual session in Chicago, June 21-25.

Death Rate Reaches New Low in 1946

The year 1946 marked a new record low for crude death rate in the United States, according to figures of the National Office of Vital Statistics. The death rate for the year was 10.0 per 1,000 population as compared with the rate of 10.6 for 1945 and the previous lowest rate was 10.4 for 1942. The total number of deaths in 1946 was 1,395,617, or 6,102 fewer than in 1945.

The estimated death rate for the United States in 1947, based on data for the first 10 months, was 10.1.

Deaths from diseases of the heart increased for the third consecutive year. Cancer and other malignant tumors continued to increase in importance as causes of deaths.

No. 1 Medical News Story

From the standpoint of volume, the selection by the House of Delegates of the American Medical Association of Dr. Archer C. Sudan, of Kremmling, Colo., as the No. 1 general practitioner of the nation in 1947, was the No. 1 medical news story of the year. According to the A.M.A., it was played up in most of the newspapers of the country.

Army Moves To Raise Standards Of Medical Education Program

In an effort to place Army teaching hospitals on an equal plane with the best civilian teaching hospitals, Maj. Gen. Raymond W. Bliss, surgeon general of the Army, recently announced adoption of a number of changes in the Army Medical Department graduate professional education program for the coming year. Changes are based on a study of nine months' operation of the program and surveys made by nine teams of civilian medical experts, he said.

Graduate training in psychiatry is being strengthened and concentrated in three general hospitals—Letterman, San Francisco; Fitzsimons, Denver; and Walter Reed, Washington, D.C. Other changes include: Addition of civilian consultants; transfer of routine paper work to administrative assistants; revision of system of selection and progress evaluation; and revision of pyramidal system among advancing students.

In December, 204 Regular Army Medical Corps officers were participating in the postgraduate instruction program as residents in the various recognized special fields of medicine and surgery. The objective of each is certification as a diplomate by one of the 16 American Specialty Boards in the field of medicine and surgery.

Fifty positions were made available on Jan. 1, and 50 more will be offered to applicants overseas effective July 1.

In December, there were 334 applications for Army internships for 168 spaces divided among Brooke, Letterman, Fitzsimons, Walter Reed, and Oliver General Hospitals. Senior medical students applied from 55 Class A medical schools. This compares with the total of 55 applications received last year, of which 21 candidates were accepted.

Of 106 applicants approved by December for internships beginning July 1, 13 had a scholastic standing among the first 10 of their class. Thirty others stood in the first third of their respective classes and 58 were in the middle third.

Ohio Doctors Play Leading Roles in Exhibits and Other A.M.A.-Week Activities

OHIO doctors of medicine had major roles in the four-day scientific exhibit which was presented January 5, 6, 7, and 8 as one of the features of A.M.A. Week in Cleveland. The exhibits were located in the Cleveland Public Auditorium.

Clinical demonstrations and conferences on cancer, dermatology, diabetes, and conservation of hearing were presented with patients supplied through the cooperation of Cleveland physicians.

Examinations in connection with cancer detection were made by staff members of the Cleveland hospitals which operate such clinics, while doctors attending the A.M.A. meeting served as subjects. The project was sponsored by the Ohio State Medical Association Cancer Committee; Cleveland Academy of Medicine Cancer Committee; Ohio Department of Health; American Cancer Society; and the Elsa W. Pardee Foundation.

COMMITTEES

Committees in charge were as follows: General Committee: Dr. H. T. Karsner, Cleveland, Chairman; Dr. A. F. Scheele, Washington, D.C.; and Dr. L. A. Pomeroy, Cleveland. Coordinating Committee: Dr. J. H. Lazzari, Chairman; and Mrs. Wayne Evans, both of Cleveland. Sub-Committee on Detection Center, Drs. J. R. Andrews, Chairman; S. O. Freedlander, F. T. Gallagher, Marion N. Gibbons, H. T. Karsner, R. S. McGinness, and U. V. Portmann, all members of the Cancer Committee of the Cleveland Academy of Medicine.

Drs. Charles D. Dolezal, R. B. Crawford, and W. B. Seymour, all of Cleveland, served on the sub-committee on equipment, and the sub-committee on display included Drs. Bruno Gebhard, Cleveland; John D. Porterfield, Columbus; Carl A. Hamann, Cleveland; and Louis Herget Cleveland.

DERMATOLOGICAL SOCIETY

Dr. John E. Rauschkolb, Cleveland, was chairman of a committee of the Cleveland Dermatological Society, which presented the following clinical demonstrations: "Scabies and Impetigo: Diagnosis and Treatment", Drs. Herbert H. Johnson and Charles G. LaRocco; "Ringworm Infections: Their Diagnosis and Treatment With Emphasis on Scalp Infections", Drs. Benjamin P. Persky and John A. Gammel; "Dermatitis Venenata: Industrial and Household Irritants", Drs. George M. Stroud and Clyde L. Cummer; "Birthmarks: Diagnosis and Treatment", Drs. Gerard A. DeOreo and H. G. Miskjian; "Syphilis Diag-

nosis and Therapy with Emphasis on Penicillin in the Treatment of the Disease", Drs. Harold N. Cole and George W. Binkley; "The Significance of the Blood Serology for Syphilis", Drs. Benjamin Levine and Benjamin S. Kline; "Skin Cancers: Diagnosis and Treatment", Dr. James R. Driver and Earl W. Netherton. In addition to the demonstrations and conferences, the above-named members of the society presented exhibits in connection with the specific subjects assigned to them.

Ohio participants in the diabetes clinics and conferences included Dr. Henry J. John, Cleveland, who conducted clinics on "Control of Diabetes" and "Diabetes in Childhood"; Dr. Henry H. Bromley, Cleveland, a paper on "Use of Insulin and Avoidance of Hypoglycemia"; Dr. Thomas P. Sharkey, Dayton, "Pregnancy and Complications in Diabetes" and "Treatment of Diabetic Neuropathy"; Dr. Cecil Striker, Cincinnati, "The Diabetic in Your Office"; and Dr. E. Perry McCullough, Cleveland, "Experimental Diabetes in Relation to Present Treatment".

HEARING DEMONSTRATION

Dr. Charles E. Kinney, Cleveland, was a participant in the conservation of hearing demonstrations.

A scientific exhibit on "Clinical Microscopy of the Surface of the Skin" was presented by Drs. Leon Goldman, W. McDaniel, Waldo Younker, and Siebentritt, University of Cincinnati College of Medicine.

Other exhibits included: "Cancer of the Skin and Mucous Membrane", Drs. Harold N. Cole and James R. Driver, Cleveland; "Contact Roentgen Therapy for Superficial Lesions", Dr. U. V. Portmann, Cleveland; "Medical Problems Encountered in the Manufacture of American-Made Rubber", Dr. Rex H. Wilson, Akron; "Ununited Fractures of the Neck of the Femur: Their Causes and Treatment", Dr. James A. Dickson, Cleveland; "Virus Pneumonias", Drs. H. S. Van Ordstrand and V. Sundgren, Cleveland.

"Anomalous Lesions of the Urinary Tract", Dr. C. Robert Hughes, Cleveland; "Standards of Human Skeletal Maturation for Lower Extremity", Dr. Carl C. Francis, Cleveland; "Dog Bites", Dr. P. L. Harris and L. F. Ey, Ohio Department of Health; "Respiratory Acidosis and Alkalosis in Children", Drs. Samuel Spector and Charles F. McKhann, Cleveland.

"The Protection of the Phosphorus Metabolism of Newly Born Infants by the Early (Eighth

Day) Parenteral Administration of a Single, Small Dose of Vitamin D₃ in Oil", Dr. Henry J. Gerstenberger, Cleveland; "Prophylaxis of Endemic Goiter", Dr. O. P. Kimball, Cleveland; "New Visual Teaching Aids for Physicians", Dr. Bruno Gebhard, Cleveland.

"The Fenestration Operation for Deafness", Dr. Harold E. Harris, Cleveland; "Hematologic Dyscrasias—Precise Diagnosis; Specific Therapy", Drs. Charles A. Doan and Claude-Starr Wright, Columbus; "Gastrosocopy; Model Demonstration", Dr. H. R. Rossmiller, Cleveland; "Vagotomy for Duodenal Ulcer", Drs. T. E. Jones and George Crile, Jr., Cleveland; "The Value and Limitations of the Electrocardiogram", Dr. A. Carlton Ernsthene, Cleveland.

INDUSTRIAL HEALTH CONGRESS

Ohio doctors of medicine who participated in the program of the Eighth Annual Congress on Industrial Health, held January 5 and 6, at the Cleveland Auditorium, during A.M.A. Week, include Dr. George Sykes, Cleveland, who presided over the opening session; Dr. H. P. Worstell, Columbus, who presided during the Conference on Administrative Practices; and Dr. Robert A. Kehoe, Cincinnati, who led the "Conference on Industrial Physiology".

Other Ohio doctors attending the A.M.A. meeting in an official capacity included Ohio delegates to the session, listed in the special article on actions of the House of Delegates, elsewhere in this issue, and Dr. E. J. McCormick, Toledo, a member of the A.M.A. Board of Trustees; Dr. Russell L. Haden, Cleveland, member of the Council on Medical Education and Hospitals of the A.M.A.; Dr. Torald Sollmann, Cleveland, Chairman of the Council on Pharmacy and Chemistry; Dr. Richard L. Meiling, Columbus, Secretary of the Council on National Emergency Medical Service.

COMMITTEE ON ARRANGEMENTS

The Cleveland Committee on Arrangements included Dr. Clyde L. Cumber, Chairman; Sub-Committee on Hotels: Dr. David Chambers, Chairman, and Drs. A. K. Cieslak, W. B. Cleveland, P. F. Gulmi, and P. J. Schildt. Sub-Committee on Information and Registration included: Dr. R. F. Parker Chairman, and Drs. Fay A. LeFevre, E. F. Kieger, C. D. Waltz, and Mr. H. Van Y. Caldwell. Sub-Committee on Scientific Exhibit: Dr. C. F. McKhann, Chairman, and Drs. Spencer Braden, A. C. Ernsthene, Louis W. Ladd, R. S. McGinnis, and John E. Rauschkolb.

Attending from the Headquarters Office of the Ohio State Medical Association were: Charles S. Nelson, executive secretary; George H. Saville, director of public relations; and Hart F. Page, assistant director of public relations.

Percentage Occupancy of Beds in Hospitals Is Increasing

A steady increase in the percentage of occupancy of Ohio general hospitals' beds was experienced in the three-year period 1944-46, according to the December issue of the *Ohio Hospital Survey Bulletin*.

The survey shows the following percentages: 72.1 per cent in 1944; 73.6 per cent in 1945; and 75.2 per cent in 1946. The average for the period was 73.8 per cent.

Some of the factors thought to influence this increase are (1) A more thorough understanding and acceptance of present-day preventive and curative medicine; (2) increased number of people now possessing hospitalization insurance, bringing hospital care to many more people at a cost the average family can better afford; (3) unprecedented number of births now occurring in hospitals, coupled with the general reluctance of physicians to deliver babies anywhere but in hospitals; and (4) the present economic prosperity of the majority of wage earners.

Predicted percentage of occupancy, based on estimates of 157 hospitals, is a high of 89 per cent, average of 74, and low of 59.

Of 21,736 beds in Ohio general and special hospitals, 88 per cent or 19,130 are classified as "acceptable".

During the same three-year period, although the number of deaths in hospitals increased, the ratio of deaths per patient days in hospitals decreased. The survey shows the following statistics: 1944, number of patient days per death, 266.4; in 1945 the number of patient days had increased to 276.9; and in 1946 was 289.0

Field Assumes A.M.A. Post

Oliver F. Field, of Denver, who served with the Federal Food and Drug Administration, has taken over the work connected with the American Medical Association Bureau of Investigation. As administrative assistant in the Division of Therapy and Research, Mr. Field will direct primarily the affairs of the Bureau of Investigation, and is assigned to give assistance to the Councils on Pharmacy and Chemistry, Foods and Nutrition, and Physical Medicine. A graduate of the Law School of the University of Notre Dame in 1931, he is a member of the Illinois Bar.

Microbiology Dept. Opened

A department of microbiology has been set up in the Western Reserve University School of Medicine, Cleveland. Dr. Lester O. Krampitz has been promoted from the position of associate professor of biochemistry in the department of biochemistry to head the new department as professor of microbiology.

New Items Added to Schedule of Indemnities of Ohio Medical; Coverage Now Offered in 82 Counties

BASED on experience derived from its two years of operation, Ohio Medical Indemnity, Inc., "The Doctors' Plan" for voluntary prepayment medical care, has, by action of the Board of Directors, added a number of items to its schedule of indemnities, and has adjusted upward the payments for certain other procedures, without increasing the monthly fees to subscribers.

The organization also announced that as of January 31, enrollment has reached a total of approximately 310,000 persons, with about 1,800 groups represented.

Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, reported that with the beginning of its third year the company is expanding its operations into another area, the eight-county territory covered by Hospital Service, Inc., Lima, the Lima Blue Cross plan. Counties added by this action are: Van Wert, Mercer, Putnam, Allen, Auglaize, Shelby, Hancock, and Hardin.

COUNTIES COVERED TOTAL 82

The addition of this area brings the total number of counties covered by "The Doctors' Plan" to 82. The enrollment policy which had been in effect in the Cincinnati, Columbus, Toledo, Akron, and Canton areas will be followed in the Lima agreement. Subscribers will be enrolled only in groups, and they will be holders of Blue Cross hospitalization contracts.

An agreement has been established between Ohio Medical Indemnity and Hospital Service, Inc., of Lima, whereby the latter will perform certain administrative services in connection with the issuance and distribution of the medical prepayment contracts in the area. Paul J. Lynch, executive director of Hospital Service, Inc., will serve as agent there for Ohio Medical Indemnity.

ADDITIONS TO INDEMNITY SCHEDULE

One of the important additions to the indemnity schedule was an indemnity of up to \$10 for the suturing of wounds in the doctor's office, or elsewhere, within 24 hours following an accident. This service previously was covered only when the surgical service was rendered in a hospital.

Other added indemnities include, under "Abdomen", the procedure of "Gastro-enterostomy", \$125; under "Breast", the procedure of "Biopsy", \$25; under "Chest", the procedure, "Pleura, paracentesis" first operation, \$5, and each subsequent operation, maximum of five, \$5; under "Ear, Nose, or Throat", the procedure "Paracentesis tympani", first operation, \$5, and each subsequent operation, with a maximum of five, \$5.

The indemnity for amputation of the thigh through hip joint or neck of femur or arm through shoulder joint, was raised from \$100 to \$125. Mastoidectomy on one side was raised from \$75 to \$100, and on both sides, from \$100 to \$150.

Excision or fixation by cutting of hip or shoulder joint was increased from \$100 to \$125, and of joints of elbow, wrist, or ankle, from \$50 to \$75.

OTHER CHANGES MADE

Cutting on extrinsic eye muscles, for one eye, one or more stages, was raised from \$35 to \$75; and for both eyes, one or more stages, from \$70 to \$100.

Cystoscopic examination of the genito-urinary tract was increased from \$10 to \$15; while cystoscopy for removal of urinary stones or bladder tumor was boosted from \$25 to \$35 for the first operation; and from \$10 to \$15 for each subsequent operation. The resection of a single fistula of the rectum was raised from \$35 to \$50.

The age limitation on circumcision was reduced from 12 years to 30 days of age. This means that circumcision will now be indemnified after 30 days of age, where previously it was paid for only when the subscriber was 12 years old or older.

COMING MEETINGS

Ohio State Medical Association, Cincinnati, March 30-April 1.

American Medical Association Annual Meeting, Chicago, June 21-25.

American Association for the Study of Goiter, Toronto, Canada, May 6-8.

American College of Allergists, New York City, March 12-14.

American Urological Association, Boston, May 17-20.

Mahoning County Medical Society, 19th Annual Postgraduate Assembly, Youngstown, April 14.

Michigan Postgraduate Clinical Institute, Detroit, Mar. 10-12.

National Society for the Prevention of Blindness, 1948 Conference, Hotel Radisson, Minneapolis, Minn., April 5-7.

Northern Tri-State Medical Association, Findlay, April 13.

Dr. Louis K. Diamond, hematologist and assistant professor of pediatrics at Harvard Medical School, has been appointed technical director of the American Red Cross National Blood Program.

Two Key Officers Added in Ohio Health Department Reorganization Program; Functions Outlined

AS part of a reorganization program for the Ohio Department of Health, Dr. John D. Porterfield, director, has announced the appointment of two key officers in the organization. They are Dr. Paul Q. Peterson, 577 S. Harris Ave., Columbus, as chief of the new Bureau of Direct Services; and Dr. Walter B. Lacock, 108 W. Cooke Rd., Columbus, as chief of the recently-created Cancer Division.

Dr. Peterson, 35, received his medical degree from the University of Illinois College of Medicine, and the degree of Master of Public Health from the University of Michigan School of Public Health. The new chief had his internship in Bethesda Hospital, Cincinnati, and his residency training in Memorial Hospital, Lima. He engaged in private practice of medicine for several years before entering public health work. He has had experience in local and state health departments and was for a time the health director of a state teachers' college.

Dr. Lacock received his medical degree from the Ohio State University College of Medicine in 1926. He was associated with public health work from 1930 to 1940, first in the Ohio Department of Health as an inspector in the Communicable Disease Division, and later in the Hocking-Vinton General Health District. He served in the Army Medical Corps from October, 1940, until December, 1947, when he was discharged with the rank of colonel. For the last year-and-a-half he was chief of public health for the military government with headquarters at Ryukyus in the Far East.

THREE MAIN BRANCHES

Under the former plan, all division chiefs of the Department of Health worked immediately under the director. Under the new plan, units are grouped into three branches—the Bureau of Local Services, the Division of Administration, and the Bureau of Direct Services.

Chiefs of the seven divisions under the Bureau of Local Services are: Communicable Diseases, P. L. Harris, M. D.; Venereal Diseases, Charles R. Freeble, M. D.; Tuberculosis, Arnold B. Kurlander, M. D.; Cancer, Dr. Lacock; Child Hygiene, Susan P. Souther, M. D.; Dental Hygiene, Harry B. Milhoff, D. D. S.; and Nursing, S. Gertrude Bush, R. N.

Chiefs of the four divisions and the Hospital Facilities Office under the Bureau of Direct Services are: Sanitary Engineering, F. Holman Waring; Laboratories, Leo. F. Ey; Vital Statistics, William Veigel; Industrial Hygiene, Thomas F. Mancuso, M. D.; and Hospital Facilities, A. J. Borowski, Dr. P. H. Dr. Borowski, before assum-

ing his new position, was registrar and superintendent of the Bureau of Vital Statistics, Toledo Board of Health.

In addition to coordinating the functions of these direct service divisions, Dr. Peterson will be responsible for the public health training program of the Department, including the establishment of local field training centers. He also will act as liaison officer with coordinated state agencies, such as the Department of Education, the Department of Public Welfare, Ohio State University, and others.

The Department's Division of Administration is being continued as a separate division with an expanded program of centralized services. Key officers under the Division of Administration are: Personnel officer, fiscal officer, biostatistician, and health educator. James E. Bauman, assistant director and legal advisor of the Department, will continue as chief of the Division of Administration.

WORK WITH LOCAL UNITS

The Bureau of Local Services will devote its activities particularly to consultative and advisory services to local health departments and to the development of cooperative budgets from Federal grant-in-aid funds available to full-time local departments. The growing interest and concern of Ohio's citizens in matters of public health and the intensified need of full-time coverage of all parts of the state make this increase of service necessary, Dr. Porterfield pointed out.

The new organization of the State Department is necessary because of the growing complexity of the state's public health program and the greater need of providing efficient consultant service to Ohio's local health units and to the other branches of state government, according to Dr. Porterfield. Recent state and Federal legislation added new duties to the Department's program. Most recent additions are the Division of Cancer, and the Hospital Facilities Office which is responsible for the Ohio Hospital Survey.

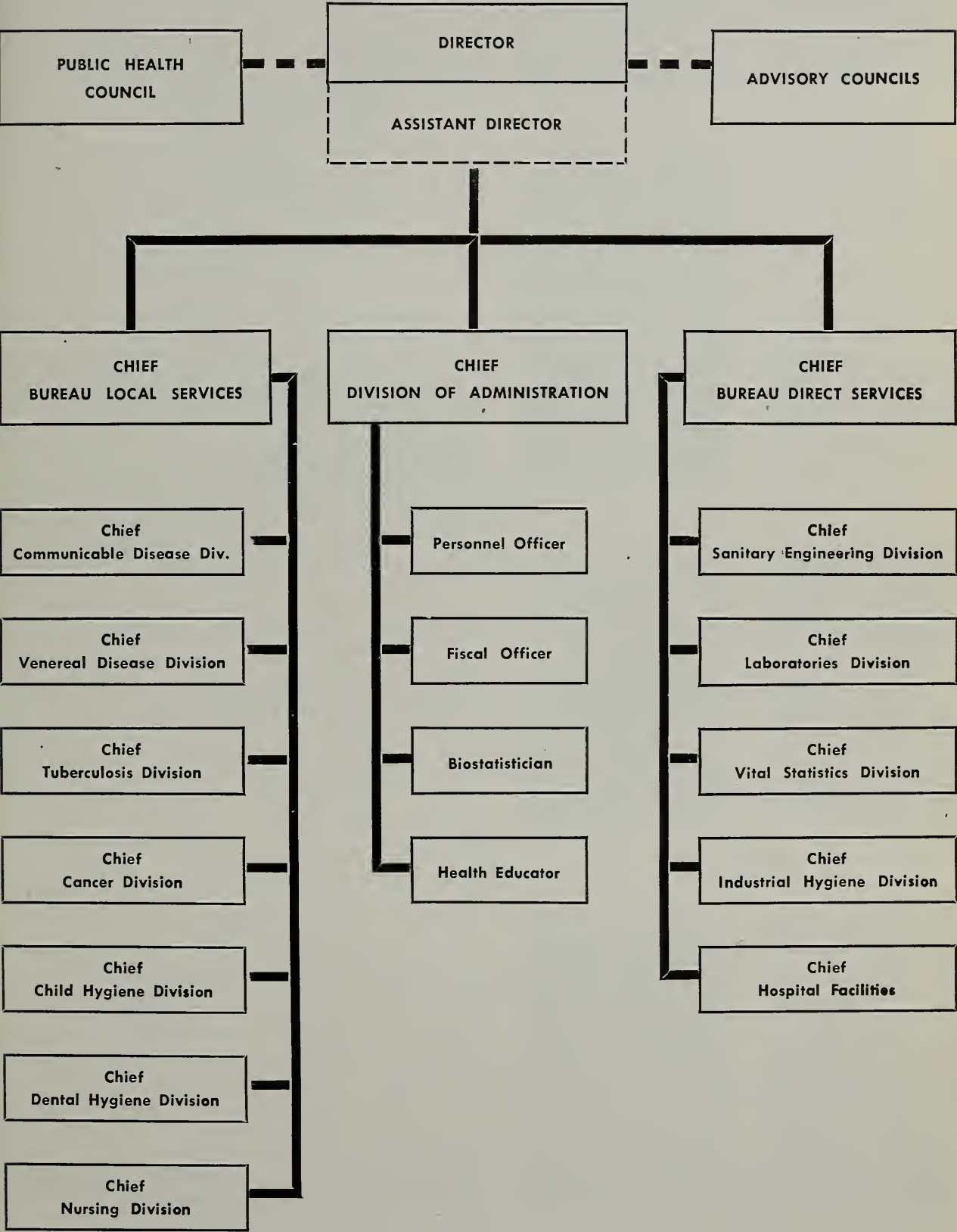
The Ohio Public Health Council, rule making and quasi-judicial body, consists of the following: Chairman S. F. Ridings, D. D. S., Greenville; Mrs. Lilly Cooper, Findlay, vice-chairman; J. Howard Holmes, M. D., Toledo; L. F. Huffman, M. D., Cleveland; Howard A. Hines, pharmacist, Van Wert; Phillip T. Knies, M. D., Columbus; and William Helmer, Cincinnati. Mr. Bauman is secretary of the council.

The accompanying chart shows the new organization plan.

NEW ORGANIZATION PLAN

OF

THE OHIO DEPARTMENT OF HEALTH



You Can't Afford To Miss . . .

Ohio's Best
Medical
Meeting of
1948

MARCH 30 - APRIL 1
CINCINNATI
OHIO

OHIO STATE MEDICAL ASSOCIATION
ANNUAL MEETING



Eighteen Instructional Courses . . . Addresses by
13 Guest Speakers . . . Nine Section Meetings . . .
Technical, Educational, and Scientific Exhibits
. . . Banquet with Music, Entertainment, and
Dancing . . . Fraternity and Class Reunions . . .
Program and Entertainment for the Ladies by the
Woman's Auxiliary . . . Sessions of the House
of Delegates. ♪ ♪ ♪ ♪ ♪ ♪

See Opposite Page for Data on Guest Speakers

INTRODUCING . . .

Thirteen Guest Speakers on the 1948 Annual Meeting Program

Thirteen distinguished out-of-state authorities in the fields of medicine and surgery will participate as guest speakers in the 1948 Annual Meeting of the Ohio State Medical Association in Cincinnati, March 30-April 1.

The Ohio State Medical Association is proud to be able to present these distinguished guests in addition to the many Ohio physicians scheduled on the program.

For the benefit of those not previously acquainted with these speakers, *The Journal* presents the following brief biographical sketches.

Each of the guests is an outstanding authority in his field. The speakers will bring to Ohio a variety of professional training as well as a wide range of technical application.

Richard J. Bing, M.D., Baltimore, Md., is associate professor of surgery and instructor in medicine, Johns Hopkins University, and surgeon, Johns Hopkins Hospital. He received his degree from the University of Berne, Switzerland; is a member of the American Physiological Society, the Society of Experimental Biology and Medicine, and an honorary member of the New York Academy of Medicine. Dr. Bing will speak at 10:05 a. m., Thursday, before the Section on Pediatrics on, "The Diagnosis and Surgical Treatment of Congenital Heart Disease".

Dr. Bing will describe catheterization of the heart, an exercise test, measurement of the total blood flow to the lung, and photo-electric measurement of the oxygen saturation in the blood. He also will describe a new method of diagnosis which measures coronary blood flow in man.

Bayard Carter, M. D., Durham, N. C., is obstetrician and gynecologist in chief, Duke University Hospital, and professor of obstetrics and gynecology, Duke University School of Medicine. He is a member of the American Gynecological Society; the American Association of Obstetricians, Gynecologists and Abdominal Surgeons; the South Atlantic Obstetrical and Gynecologic Society; and an examiner for the American Board of Obstetrics and Gynecology. Dr. Carter received his degree from Johns Hopkins University in 1925. He will speak at 3:15 p. m., Wednesday, before the Second General Session on, "Conservatism in the Surgery of the Uterus and the Ovaries".

Dr. Carter will present a plan for conservatism based upon anatomic, physiologic, and pathologic conditions. In a few conditions, he will attempt to show that a radical procedure may be the most conservative procedure.



R. J. BING, M.D.



B. CARTER, M.D.



W. C. C. COLE, M.D.



S. C. CULLEN, M.D.



J. B. GRANT, M.D.



W. G. MADDOCK, M.D.



A. R. MORITZ, M.D.



D. B. PHEMISTER, M.D.

Wyman C. C. Cole, M.D., Detroit, Mich., is chief of the Department of Pediatrics, Woman's Hospital, and attending physician in the Department of Pediatrics, Harper Hospital. Dr. Cole is a graduate of the University of Minnesota College of Medicine, 1918; he is a Fellow of the American Academy of Pediatrics and a member of Alpha Omega Alpha. He will speak at 10:00 a. m., Wednesday, before the Section on General Practice on, "Desirability of Breast Feeding".

Dr. Cole will analyze the decline of this natural function and will discuss the safety and value of breast milk. Particular emphasis will be placed upon the emotional and psychological value of nursing to both mother and child.

Stuart C. Cullen, M.D., Iowa City, Iowa, is chairman of the Division of Anesthesiology, University Hospitals, and associate professor of surgery (anesthesiology), University of Iowa College of Medicine. He is a member of the American Society of Anesthesiology, the Society for Experimental Biology and Medicine, the Society for Experimental Pharmacology and Therapeutics, the Central Surgical Association, the Argentine Anesthesiologic Society, the American Medical Association; and is associate editor of *Anesthesiology*. Dr. Cullen will talk on, "Indications for Use of Curare", in a panel discussion at 9:15 a. m., Tuesday, before the Section on Anesthesiology.

John B. Grant, M.D., New York City, is director for the European Region, International Health Division, The Rockefeller Foundation, with offices in Paris, France. A graduate of the University of Michigan Medical School, Dr. Grant received a Certificate of Public Health from Johns Hopkins University in 1921. He is a Fellow of the American Public Health Association. Dr. Grant will speak at 9:15 a. m., Wednesday, before the Section on Public Health and Preventive Medicine on, "International Trends in Medical Care", as a part of the theme of the section program, "Medicine and the Changing Order".

In the past two years, Dr. Grant has surveyed 12 countries for The Rockefeller Foundation to learn the degree of health and medical care in each, standards of nutrition, housing, recreation, education, and social security.

Walter G. Maddock, M.D., Chicago, is associate professor of surgery, Northwestern University Medical School; is on the attending staff of Wesley Memorial Hospital and the courtesy staff of Passavant Hospital. A graduate of the University of Michigan Medical School, 1927, Dr. Maddock is a member of the American Surgical Association, the Society of Clinical Surgeons, Central Surgical Association, Western Surgical Association, American Heart Association, and other professional organizations. He will speak at 9:30



EDITH L. POTTER, M.D.



M. C. SOSMAN, M.D.



G. H. TWOMBLY, M.D.



D. VAIL, M.D.

a. m., Thursday, during the Section on Surgery on, "Fluid Balance in Surgical Patients".

Alan Richards Moritz, M.D., Boston, Mass., is professor of legal medicine, Harvard Medical School, lecturer in legal medicine at Boston University Medical School and Tufts Medical School. Dr. Moritz received his degree from the University of Nebraska College of Medicine in 1923. He is a member of the American Medical Association; the American Board of Pathology; the American Association of Pathology and Bacteriologists; the American Association for the Advancement of Science; the American Society of Experimental Pathologists; the American Society for Cancer Research; and the Massachusetts Medico-Legal Society. He will speak at 3:15 p. m., Tuesday, before the First General Session on, "Investigation of Deaths in the Interests of Public Safety".

Dr. Moritz will include in his talk a description of the kinds of laws and the kind of public agency that are required to protect the public interests in regard to investigation of deaths.

Dallas B. Phemister, M.D., Chicago, is professor emeritus, The University of Chicago School of Medicine, and surgeon, The University of Chicago Clinics. He received his degree from Rush Medical College in 1904. Dr. Phemister is a member of the American Surgical Association,

the American Orthopedic Association, and the American College of Surgeons. He will speak at 3:50 p. m., Tuesday, before the First General Session on, "The Treatment of Selected Cases of Bone Sarcomas by Resection and Bone Transplantation".

Edith L. Potter, M.D., Ph.D., Chicago, is pathologist, Chicago Lying-in Hospital, and associate professor of pathology, Department of Obstetrics and Gynecology, University of Chicago Medical School. She received her M.D. degree from the University of Minnesota Medical School in 1925 and her Ph.D. degree from the University of Minnesota in 1934. Dr. Potter will speak at 9:30 a. m., Tuesday, before the Section on Obstetrics and Gynecology on, "The Rh Factor in Obstetrics".

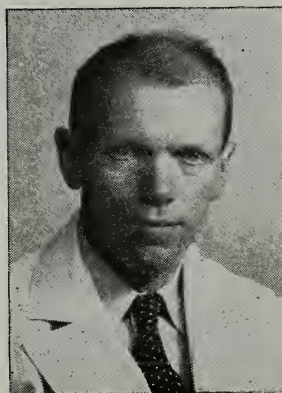
Dr. Potter will discuss from practical experience the newest findings on the Rh Factor.

Merrill C. Sosman, M.D., Boston, Mass., is radiologist to Peter Bent Brigham Hospital and clinical professor of radiology, Harvard Medical School. He received his degree from Johns Hopkins Medical School in 1917; he is a member and past-president of the American Roentgen Ray Society and of the Harvey Cushing Society, and a member of the Radiological Society, the American College of Radiology, and the American Academy of Arts and Sciences. Dr. Sosman will give two addresses. At 9:30 a. m., Wednesday, he will speak at the Annual Meeting of the Ohio State Radiological Society on, "Venous Catheterization of the Heart"; and at 3:30 p. m., Wednesday, before the Second General Session on, "Pitfalls in Roentgen Examination of the Gastro-Intestinal Tract".

Gray H. Twombly, M.D., New York City, is assistant professor of cancer research, College of Physicians and Surgeons, Columbia University; assistant surgeon, Memorial Hospital, New York City; consulting surgeon, Stamford Hospital, Stamford, Conn.; and consulting surgeon (tumor), Norwalk General Hospital, Norwalk, Conn. A graduate of Harvard Medical School, 1929, Dr. Twombly is a Diplomat of the American Board of Surgery, Fellow of the New York Academy of Medicine, and a member of the American Cancer Research Society, the American Radium Society, the Society for the Study of Internal Secretions, the New York Academy of Sciences, and the American Medical Association. He will speak at 9:30 a. m., Tuesday, before the Section on Medicine on, "Endocrine Aspect of Malignant Tumors".

Derrick Vail, M.D., Chicago, is professor and chairman of the Department of Ophthalmology, Northwestern University Medical School; attending ophthalmologist, Passavant Memorial Hos-

pital and Cook County Hospital, and consulting ophthalmologist, Wesley Memorial Hospital. Dr. Vail graduated from Harvard Medical School in 1923; he is a Fellow of the American College of Surgeons, a member of the Section on Ophthalmology, American Medical Association, the American Ophthalmological Society, Association for Research in Ophthalmology, the American Academy of Ophthalmology and Otolaryngology, and the Chicago Ophthalmological Society. He will speak at 11:15 a. m., Wednesday, before the Section on Eye, Ear, Nose and Throat on, "Surgical Treatment of Glaucoma and Its Complications".



H. G. WOLFF, M.D.

Harold G. Wolff, M.D., New York City, is associate professor of medicine and of psychiatry, Cornell University Medical College; is in the Department of Medicine (Neurology), Cornell-New York Hospital; is attending physician in neurology, New York Hospital, consulting neurologist, Westchester Division, White Plains Hospital, and associate attending psychiatrist, Payne Whitney Psychiatric Clinic, New York Hospital. Dr. Wolff received his M.D. degree in 1923 and his A.M. degree in 1928 from Harvard University. He is a Fellow in the American College of Physicians, the American Medical Association, and the American Association for Advancement of Science; and is a member of the American Neurological Association, the American Physiological Society, the American Psychiatric Association, the American Society for Clinical Investigation, the Association for Research in Nervous and Mental Disease, the Harvey Society, the International League Against Epilepsy, and many other professional organizations. Dr. Wolff will speak at 4:25 p. m., Wednesday, before the Second General Session on, "Headache Mechanisms".

New Surgeon General Appointed

President Truman has appointed Dr. Leonard A. Scheele to succeed Dr. Thomas Parran as Surgeon General of the U. S. Public Health Service, effective at the end of Dr. Parran's term of office on April 6.

Dr. Scheele has been director of the National Cancer Institute since last July. A native of Fort Wayne, Ind., he received his degree from the Fort Wayne College of Medicine in 1934. During the war he served in Italy and later with SHAEF.



Last Call !!

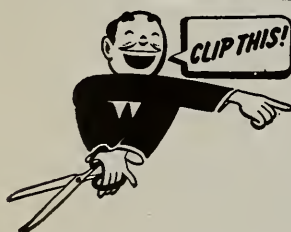
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ANNUAL MEETING

OHIO STATE MEDICAL ASSOCIATION

Cincinnati, Ohio - March 30 thru April 1

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BROADWAY, Fourth and Broadway	\$3.00		\$5.00-\$ 6.00
FOUNTAIN SQUARE, Fifth and Vine	\$3.00-\$ 4.00	\$4.50-\$ 5.50	\$5.50-\$ 6.50
GIBSON, Fifth and Walnut	\$3.25-\$12.00	\$5.50-\$12.00	\$6.00-\$12.00
METROPOLE, 609 Walnut	\$2.50-\$ 6.00	\$4.00-\$10.00	\$5.00-\$10.00
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You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, March 30, 31, and April 1, or for such other period as may be indicated herein.

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☐ Twin Bed Room with bath ☐ Suite

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**IRRITABLE
BOWEL
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“Therapeutic efforts toward the relief of constipation in patients with an irritable bowel syndrome must be continued over prolonged periods of time. Cathartics which exert their action by direct irrigation of the intestinal mucosa have no place in long-term bowel management. . . . The most satisfactory results were obtained with a hydrophilic mucilloid [Metamucil] prepared from psyllium seed. .-.”*

METAMUCIL

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*Dolkart, R. E.; Dentler, M., and Barrow, L. L.: The Effect of Various Types of Therapy in the Management of the Irritable Bowel Syndrome, *Illinois M. J.* 90:287 (Nov.) 1946.

SEARLE

**RESEARCH
IN THE SERVICE
OF MEDICINE**

Specialization, Activities of A.M.A., Legislation, and Public Relations Discussed at Midwest Conference

FIVE years of general practice after two years' rotating internship as the prerequisite for eligibility to certification by American specialty boards was suggested by Dr. R. L. Rutledge, Alliance, president of the Ohio State Medical Association, in his address to the Midwest Regional Conference on Medical Service, held January 4 at Hotel Cleveland, in connection with A.M.A. week in Cleveland.

Many physicians are "marking time in residencies, grasping at anything to get by their specialty boards, while the public is becoming enraged at finding it more and more difficult to get a doctor," the speaker declared.

Dr. Rutledge was introduced by Dr. E. J. McCormick, Toledo, member of the Board of Trustees of the A.M.A., who presided over the conference. Dr. C. W. Wyckoff, president of the Cleveland Academy of Medicine, welcomed the conference to his city.

A.M.A. ACTIVITIES REVIEWED

During the morning program five members of the headquarters staff of the American Medical Association participated in a round-table discussion, each enumerating the various services that his department has to offer to state associations, to county societies, to the individual physician, and to the public.

The first speaker, Dr. W. W. Bauer, director of the Bureau of Health Education, spoke of his department's work with the National Education Association on school health programs; national radio network broadcasts; a speakers bureau in the process of organization; television broadcasts; health and fitness workshops; and the health education literature produced by the bureau.

Thomas G. Hull, Ph.D., director of the Committee on Scientific Exhibit for the A.M.A., discussed exhibits and offered the aid of his department on state and local exhibit problems.

The director of the Bureau of Legal Medicine, J. W. Hollaway, Jr., said that his department was in a position to furnish data on proposed state laws involving medicine; reporting service on court decisions of medico-legal nature; reporting service on state legislation and bills introduced; advice on Federal income tax problems, and others.

REGARDING FELLOWSHIP

Reviewing the A.M.A. Fellowship setup, Mr. A. W. Stack, director of the membership, fellowship, and subscription department, emphasized the fact that a member of the A.M.A. need only

make formal application and pay his fellowship dues, in order to qualify for this designation, and that subscription to *The Journal of the American Medical Association* is automatically included in the fellowship dues. These dues are the same as the subscription price of *The Journal*. He announced that 76,000 of the A.M.A.'s 136,000 members are Fellows.

The Committee on Medical Motion Pictures of the A.M.A. will soon have 4,000 medical motion pictures indexed according to Ralph Creer, secretary to the committee. The films are for loan, rental, and/or purchase and are for the most part of a postgraduate nature, although there are a few which are suitable for lay groups. Mr. Creer asked that requests be specific and in detail as to exactly what aspect of the subject is wanted.

Dr. A. W. Adson, vice-chairman of the Council on Medical Service, discussed the activities of the Council in connection with the state and county medical societies.

REPORT ON MINE WORKERS' PROGRAM

At the conference luncheon, Dr. R. R. Sayers, chairman of the Medical Advisory Board of the United Mine Workers of America Welfare and Retirement Fund, told of the problems to be faced in bettering the health conditions of mining areas in order that the output of the nation's mine may be maintained.

Leading off the afternoon session, Dr. Joseph S. Lawrence, director of the Washington Office of the Council on Medical Service, surveyed the status of health and medical legislation in the present session of Congress.

PUBLIC RELATIONS DISCUSSION

In the round-table discussion of "Modern Medical Public Relations" which followed, the conference heard from Lester H. Perry, executive secretary of the Medical Society of the State of Pennsylvania; Hugh W. Brenneman, public relations counsel for the Michigan State Medical Society; and George H. Saville, director, Department of Public Relations, Ohio State Medical Association.

Charles S. Nelson, executive secretary of the Ohio State Medical Association, was chairman of arrangements for the conference and was assisted by a committee representing the other participating states of Illinois, Indiana, Kentucky, Michigan, and West Virginia, and by members of the executive staff of the Council on Medical Service.

A new antibacterial agent for your most resistant cases of wound and surface infections



Contains 0.2% Furacin
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another of its several advantages:

FURACIN SOLUBLE DRESSING *has proven effective*

in reducing the mixed infections of wounds and burns. Prior to treatment, Snyder et al.* found heavy growth in the majority of swab-cultures from 19 war wounds and burns. Following institution of Furacin Soluble Dressing therapy, the majority of cultures became sterile; only 4 per cent continued to show heavy growth.

Indications:

Infected surface wounds, or for the prevention of such infection
Infections of second and third degree burns
Carbuncles and abscesses after surgical intervention
Infected varicose ulcers
Infected superficial ulcers of diabetics
Impetigo of infants and adults
Treatment of skin-graft sites
Osteomyelitis associated with compound fracture
Secondary infections following dermatophytoses

LABORATORIES Inc.
NORWICH, NEW YORK

*Snyder, M. L., Kiehn, C. L. & Christopherson, J. W., Mii. Surg. 97:380, 1945.

LITERATURE ON REQUEST

Ohio Gets Go-Ahead Signal for Participation in Federal Funds for Hospital Construction

WITH approval in mid-February by the Surgeon General, U. S. Public Health Service, of the Ohio Hospital Plan, Ohio health officials are anticipating that local agencies will take full advantage of the \$2,692,125 of Federal funds now available to Ohio for hospital construction under the Hill-Burton Law (Public Law 725).

Already pending with the Ohio Hospital Facilities Unit are enough proposed hospital projects in high priority categories to assure utilization of most of the first year's appropriation, A. J. Borowski, Dr. P.H., administrator of the plan, intimated. Similarly, early bids indicate the second and subsequent years' appropriations will be enthusiastically sought after by local agencies, he assured.

Although coming at an opportune time, the Federal grant cannot be looked upon as a panacea for local hospital needs, Dr. John D. Porterfield, director of the Ohio Department of Health, warned.

According to the hospital survey there is need for an additional 14,500 general hospital beds in the state. There is further need for approximately 30,000 beds for tuberculosis, mental, and chronic disease patients. Urgent need also exists for health centers throughout the state, and there is pending need for nurses' training facilities, including nurses' homes. Under present building cost levels, over-all cost of constructing a hospital is estimated at between \$10,000 and \$14,000 per bed unit.

The Federal grant, with the two-thirds matched from local funds, after being prorated will provide possibly 10 per cent of the general hospital bed needs, Administrator Borowski estimated.

APPROVED BY ADVISORY COUNCIL

The Ohio Hospital Plan which was formulated after an extensive survey of hospital needs in the state, was approved by the Hospital Advisory Council on January 29, and subsequently was approved by the Surgeon General. The Hospital Advisory Council is by law to function as a consulting group to the Ohio Department of Health on matters relative to policy with respect to the plan. Dr. Porterfield is ex officio chairman of the council.

Basically, the Hill-Burton Law provides that the Federal Government will allot one third of the funds needed to construct and equip a hospital under an approved project, within the limits of the appropriation. The local agency, on the other hand, must show that it has available two thirds of the necessary funds, have available a proposed site, and give evidence that there will be sufficient funds available to maintain and operate the hospital after its construction.

FUNDS AVAILABLE

The Federal Law made the initial appropriation available for the fiscal year 1946-47, but

none of the states were prepared to go ahead with the plan during that year. The appropriation now available is for the fiscal year July 1, 1947-June 30, 1948. In order to participate in this appropriation, the working schedule for a project must be in by May 15, 1948.

If all of a year's appropriation is not utilized, the Federal Government may be requested to keep in reserve the unused portion to be used the following year. All of the appropriation, however, must be used by the end of the second fiscal year. Four appropriations, virtually the same as the initial amount, will be made for the fiscal years 1947-48, 1948-49, 1949-50, and 1950-51. Sometime during this period the appropriation intended for the fiscal year 1946-47 will be made available. All of the funds, to be used, must be appropriated, and work under construction by June 30, 1951.

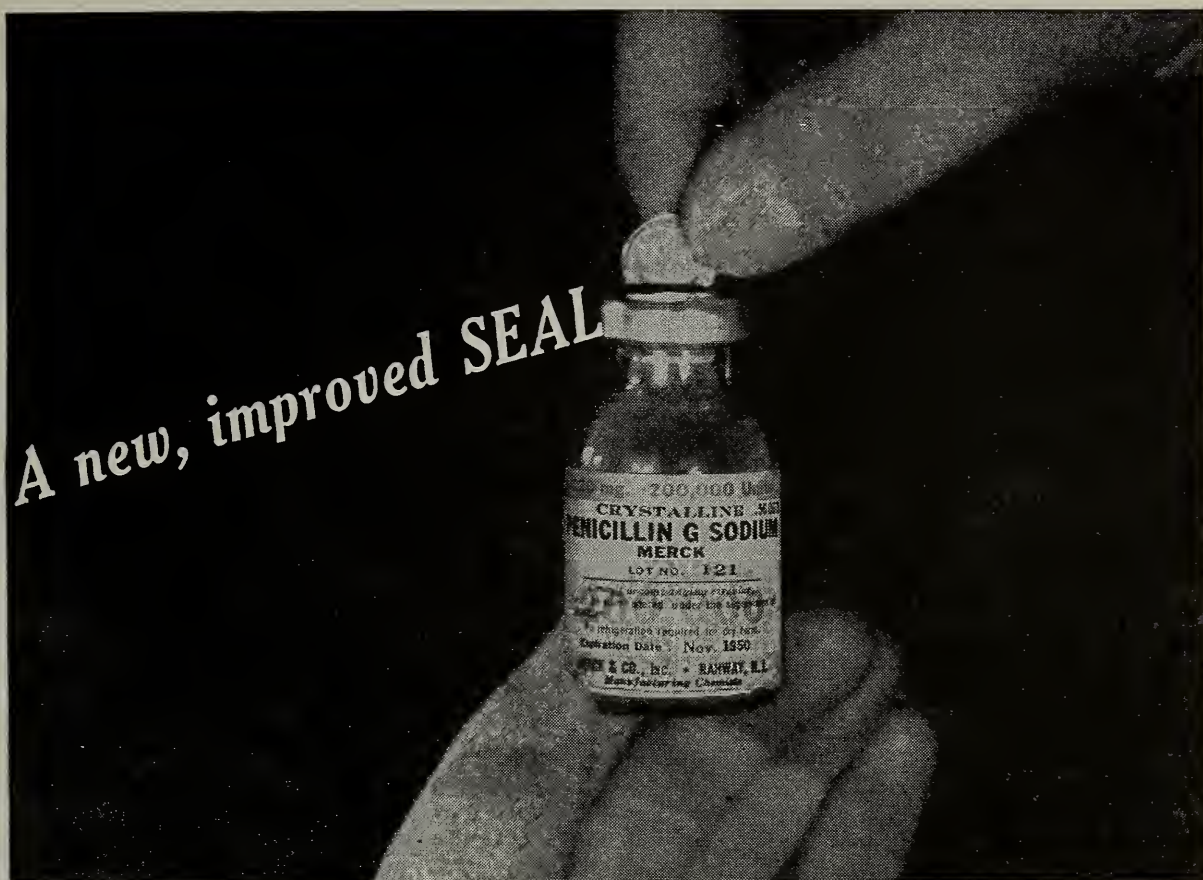
Tentative plans are that projects for possibly the first two years will be approved on a basis of general hospital bed needs. The over-all tentative plan calls for approximately 50 per cent of the appropriations for general hospitals, 30 per cent for mental, tuberculosis, and chronic disease patients' beds, 10 per cent for health centers, with the other 10 per cent to be used where experience indicates it is most needed.

PLAN NOT STATIC

The plan is not static, but is a flexible document which will be subject to revision as the program progresses and additional study is applied, Dr. Porterfield affirmed. It is a cooperative program wherein all residents of the state may and are encouraged to participate.

The plan is based mainly on the hospital survey which was conducted with Federal co-operation. In fact, the survey is closely interwoven with the plan and must be considered part of it.

In accordance with the Federal Hospital Survey and Construction Act, minimum requirements have been set forth for areas of different types;



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Crystalline Penicillin G Sodium Merck is a highly purified product from which therapeutically inert materials have been virtually eliminated.

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i.e., base, intermediate, and rural. Three base areas have been designated—Cleveland, Cincinnati, and Columbus. Each base area contains a teaching hospital of a medical school, this hospital having a complement of 200 or more beds and each area has a total population of more than 100,000. Eighteen areas have been designated as intermediate areas. Each intermediate area contains at least one general hospital with a complement of 100 or more beds and has a total population of more than 25,000. Fifty-three rural areas have been established.

PRIORITIES

The manner in which the state plan determines priority of projects conforms in general with the principles set forth in the regulations of Public Law 725.

Initial installations and additions to existing hospitals and health centers shall be given priority over replacements except where replacements are of minor nature and necessary to the provision of needed additional facilities. Also, in the case of a hospital, priority will be given where replacement is essential to eliminate an existing needed hospital which because of non-fire resistive construction or because it was not originally designed for use as a hospital, has been declared as non-acceptable.

FACTORS USED

Priorities of areas were determined according to the following factors: Per cent of needs met with acceptable beds as prime factor; distance from nearest hospital; rurality; and financial resources. The qualifying factors, nearness to large hospital, rurality, and financial resources, were each assigned weights, 1, 2, 3, and 4, and were added to give a composite factor. Under this method the most distant, most rural, and poorest areas would have a composite figure of three and the least remote, least rural, and wealthiest areas would have a composite factor of 12.

The 74 hospital areas of the state have been classified into six priority groups according to the per cent of needs met by existing hospital facilities.

AREAS CLASSIFIED

In "A" group are 12 hospital areas with zero per cent of needs met. In "B" group are nine areas with 11.7 to 34.2 per cent of needs met. In "C" group are 22 areas with 37.8 to 55.0 per cent needs met. In "D" group are 14 areas with 56.6 to 64.5 per cent needs met. In "E" group are 11 areas with 69.1 to 79.8 per cent needs met. In "F" group are six areas with 84.4 per cent or over of needs met.

Included in the "A" group are five areas which have non-acceptable hospital beds. Such communities in the group would be considered

as less urgently in need for immediate construction by comparison with communities having no beds available.

Following are the six priority groups with areas numbered according to priority within the respective groups:

GROUP A

Name	Area	% Need Met By Acceptable Beds	Total Beds	% Need Met By Total Beds	Composite Factor
1. West Union	R-13	0	0	0	3
2. Pomeroy	R-55	0	0	0	4
3. Batavia	R-4	0	0	0	4
4. Georgetown	R-3	0	0	0	4
5. Washington C. H.	R-15	0	0	0	6
6. New Lexington	R-29	0	0	0	6
7. St. Marys	R-24	0	0	0	8
8. Bowling Green	R-36	0	21	25.6	10
9. Barnesville	R-52	0	18	27.3	3
10. Ashtabula	R-33	0	13	41.0	9
11. Hillsboro	R-2	0	38	45.8	6
12. Van Wert	R-26	0	57	83.6	8

Name	Area	% Need Met By Acceptable Beds	Composite Factor
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GROUP B

1. Cambridge	R-30	11.7	5
2. Marion	I-7	17.4	9
3. Defiance	R-57	18.3	7
4. Wilmington	R-1	18.8	6
5. East Liverpool	I-18	19.1	7
6. Bryan	R-58	24.6	9
7. Xenia	R-10	26.7	8
8. Urbana	R-21	28.8	8
9. Chillicothe	R-19	34.2	5

GROUP C

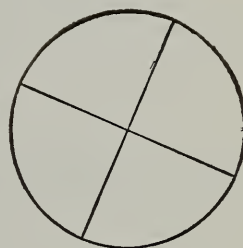
1. Athens	R-54	37.8	5
2. Piqua-Troy	R-8	37.8	8
3. Mt. Vernon	R-28	38.1	6
4. Delaware	R-16	39.3	7
5. Gallipolis	R-12	39.8	3
6. Coshocton	R-31	40.6	5
7. Dover	R-48	41.1	10
8. Findlay	R-35	43.2	9
9. Bucyrus	R-27	44.6	11
10. Painesville	R-32	44.8	12
11. Bellefontaine	R-22	47.8	6
12. Kenton	R-25	47.8	7
13. Lorain-Elyria	I-12	50.4	9
14. Circleville	R-20	51.1	6
15. Newark	I-8	51.3	9
16. Wooster	R-45	51.4	8
17. Portsmouth	I-3	52.4	6
18. Youngstown	I-17	52.4	11
19. Mansfield	I-13	53.4	9
20. Alliance	R-49	53.6	12
21. Martins Ferry	R-51	54.5	6
22. Columbus	B-2	55.0	8

GROUP D

1. Toledo	I-10	56.6	10
2. Hamilton-Middletown	I-1	57.9	10
3. Ashland	R-43	58.5	10
4. Cleveland	B-3	60.9	10
5. Springfield	I-5	61.1	11
6. Canton-Massillon	I-15	61.6	9
7. Akron-Barberton	I-14	61.6	11
8. Cincinnati	B-1	63.0	10
9. Logan	R-18	63.8	6
10. Paulding	R-56	63.9	7
11. Steubenville	I-19	63.7	7
12. Norwalk	R-42	63.6	9
13. Sandusky	I-11	64.2	10
14. Wauseon	R-34	64.5	6



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BENZEDRINE SULFATE, by safely depressing the overweight patient's appetite, ordinarily curbs excessive eating. Lowered caloric intake and loss of weight naturally follow. Hence, Benzedrine Sulfate therapy is medically sound and highly effective.

Thyroid—irrational, potentially dangerous and widely condemned

In overweight, most authorities strongly condemn thyroid therapy as irrational and potentially dangerous, except in those rare instances when an accompanying hypothyroidism has been definitely demonstrated.

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Harris, Ivy and Searle,¹ after a comprehensive series of functional tests, conclude: "No evidence of deleterious effects of the drug (amphetamine sulfate) was observed."

¹Harris, S. C.; Ivy, A. C., and Searle, L. M.: THE MECHANISM OF AMPHETAMINE-INDUCED LOSS OF WEIGHT: A Consideration of the Theory of Hunger and Appetite, J.A.M.A. 134:1468 (Aug. 23) 1947.

Benzedrine* Sulfate

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of the AMA for use in treatment of overweight.



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U.S. REG. U.S. PAT. OFF. FOR RACEMIC AMPHETAMINE SULFATE, S.K.F.

Name	Area	% Need Met By Acceptable Beds	Composite Factor
GROUP E			
1. Salem	R-50	69.1	10
2. Dayton	I-2	69.4	10
3. Marietta	R-53	70.0	4
4. Lima	I-6	70.1	10
5. Fremont	R-41	71.8	10
6. Ironton	R-11	72.5	5
7. Tiffin	R-37	73.0	9
8. Lancaster	R-17	76.3	8
9. Sidney	R-9	77.0	8
10. Greenville	R-7	79.4	6
11. Zanesville	I-9	79.8	7
GROUP F			
1. Warren	I-16	84.4	11
2. Port Clinton	R-40	86.2	8
3. Medina	R-44	89.8	8
4. Celina	R-23	91.4	5
5. Millersburg	R-47	109.5	6
6. Ravenna	R-46	166.7	9

PROJECT CONSTRUCTION SCHEDULE

The State Agency will develop a Project Construction Schedule which will list the projects for which construction can be started immediately. The schedule will be developed by soliciting applications from sponsoring agencies in areas of the greatest unfilled need and in the order of the area priorities as shown in the over-all construction program. The number of projects included in the schedule will depend upon the amount of the Federal allotments to the state.

Projects will be selected for the schedule after consideration of the following factors:

1. Priority of the project;
2. Intent to begin construction within reasonable time;
3. Ability of sponsoring agency to meet financial requirements for construction, maintenance, and operation; and
4. The maintenance of an appropriate balance in the construction of the various categories of facilities (i.e., general, tuberculosis, mental, and chronic disease hospitals, and public health centers). The balance between categories of facilities will not necessarily be reflected in each project construction schedule. However, construction which is scheduled over the five-year period will reflect an appropriate balance between the various categories of facilities.

FURTHER CONDITIONS

If a project is removed from the schedule, the schedule will be revised to include the next highest priority project.

The fact that a project is excluded from the schedule for any of several reasons will not change the project priority rating, although for other reasons this priority may change. Such projects will be considered for inclusion in each succeeding schedule.

If a project is in the highest priority group, Part I of the Project Construction Application, which is prescribed by the U. S. Public Health Service, may be approved and forwarded prior to approval of the schedule. If the project is not in the highest priority group, Part I will be submitted with the schedule.

The first schedule will be submitted to the appropriate Public Health Service District office no sooner than two months after approval of the state plan. The schedule will be submitted on or before July 1 of each year.

Applications for financial assistance will be submitted on the Project Construction Application form. These are available through the Ohio Hospital Facilities office.

Following are some provisions of the plan drawn from experiences of the survey:

DETERMINATION OF NON-ACCEPTABLE BEDS

In considering existing beds for purposes of long-range planning only those beds in the highest type of fire resistive buildings are counted as acceptable. Beds are listed as non-acceptable which are housed in non-fire resistive buildings, or in buildings or parts of buildings not originally built as hospitals. Many beds which were listed as non-acceptable will continue to be used until such time as replacements are effected.

NON-DISCRIMINATION

An applicant must assure that it will make its facilities available to all persons residing in the area to be served without discrimination as to race, creed, or color.

BED-DEATH RATIO

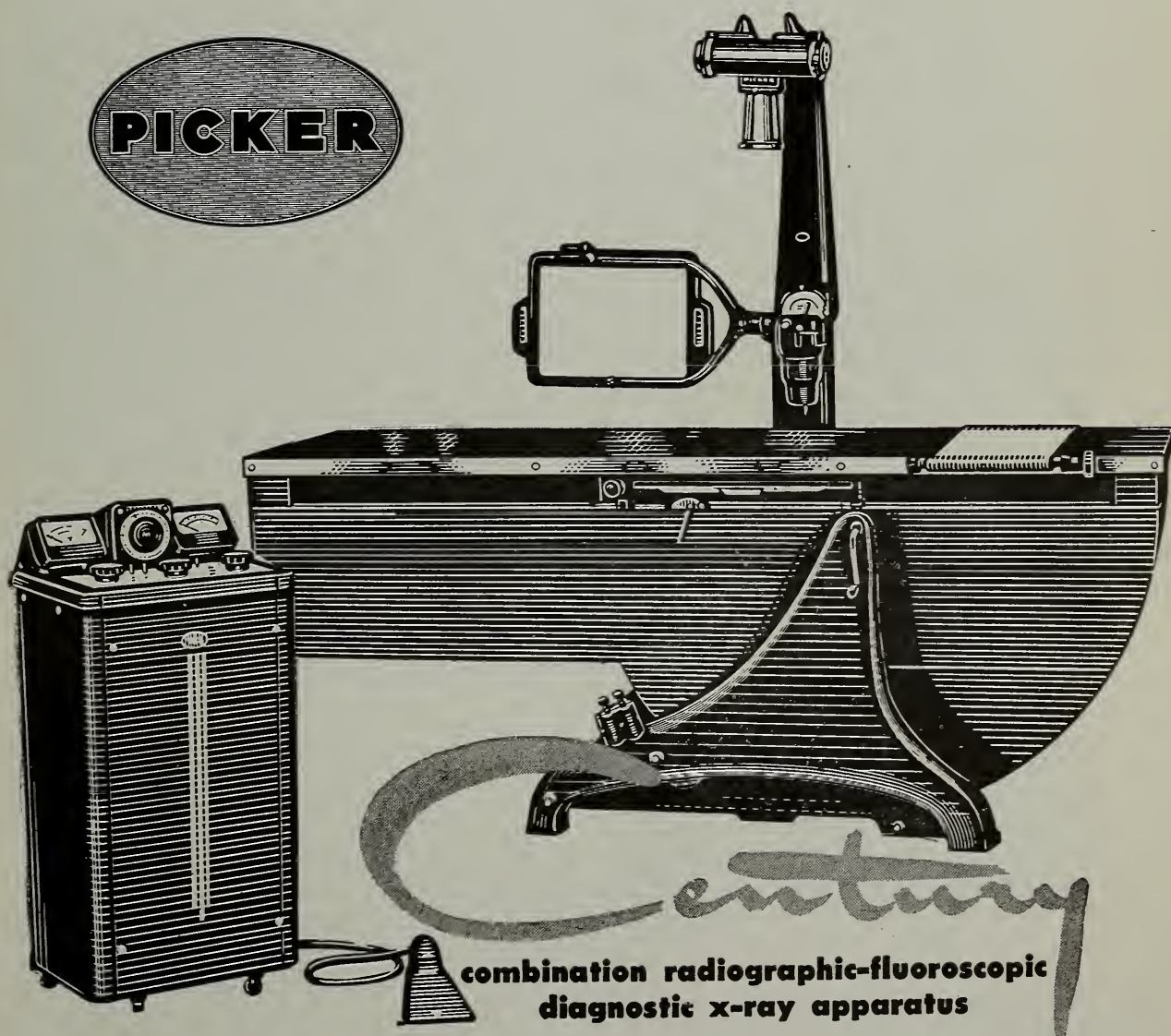
In determining the need of general hospital beds, the bed-death ratio for the period 1942-46 was used. In considering the per cent of deaths occurring in general hospitals, figures for 1946 were used. The per cent of hospital deaths has increased about one per cent a year. Therefore, in making a plan that looks ahead ten years, it was decided to set a goal for the base areas 10 per cent greater than the present experience; in intermediate areas, 15 per cent; and in rural areas, 20 per cent.

To determine the expected hospitalized death rate for any area it is necessary to multiply the total death rate for the area by the expected percentage of deaths that will occur in hospitals. This procedure will indicate the expected load of the hospital serving that area. In general it can be stated that the smaller the hospital, the lower its percentage of occupancy.

INTERSTATE SERVICE AREAS

Ohio, with five bordering states, has many interstate hospital service areas. There are four areas in which the primary hospital center

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for some Ohio people is located outside the state. There are nine areas in which the primary hospital center for some out-of-state residents is located in Ohio. The Ohio plan includes provision for the total population of the state, and, in addition, for 154,000 people who live outside the state.

As determined by the bed-death ratio, the total bed need for Ohio hospital service area is 38,300 beds. The maximum state ratio of hospital beds to population, according to Public Law 725, is 4.5 per thousand, or 33,744. For the purpose of this plan, therefore, the total bed need for each area was adjusted to 88.1 per cent of the calculated need.

BEDS NEEDED IN AREAS

There is a difference between the hospital beds needed for the people of an area and the hospital beds needed in the area. This is true because a certain number of persons are going to have illnesses that cannot be given adequate care with the facilities present in small centers and so must go to the larger areas for care.

To determine the total general hospital beds needed in the areas of the state the following procedures were adopted. In areas in which the occupied bed need was less than 75, 50 per cent of the beds were allotted to the area and the other 50 per cent to intermediate and base centers. In areas in which the occupied bed need was between 75 and 149, 60 per cent of the beds were allotted to the local area and the remainder to intermediate and base centers. If the occupied bed need was between 150 and 224, 70 per cent of the beds were allotted to the local area. Where the need was greater than 225 beds, 80 per cent were allotted locally.

Each hospital in the state has been related to one of the three base areas. The Ohio plan divides the state into 20 regions. Each region has a city designated as a hospital center which can provide the more specialized types of medical care.

PLAN FOR CHRONIC DISEASE

The state ratio for chronic disease patients, allowable under the provisions of Title 42, U. S. Public Health Service regulations, is two beds per thousand population, or 14,998. Discounting chronic disease units of ten beds or less in general hospitals, as required by law, Ohio now has 609 beds for chronic disease, all of which are considered non-acceptable. The initial plan programs approximately 25 per cent of the total allowable beds which may be constructed, or 3,658.

PLAN FOR MENTAL DISEASE

The state ratio for mental patients is five beds per thousand population, or 37,495 beds. Discounting nervous and mental disease units of

ten beds or less in general hospitals, Ohio now has 16,239 acceptable beds for nervous and mental disease. On this basis there is a need for 21,256 additional beds. The plan programs approximately 25 per cent of allowable beds. In view of the limitations of funds available to the state for hospital construction, less than 15 per cent of the programmed construction will be attempted.

PLAN FOR TUBERCULOSIS BEDS

The ratio for tuberculosis patients is 2.5 beds per death based on the average annual deaths from tuberculosis in the state covering a five-year period, or 7,103 beds. Discounting units in general hospitals, Ohio now has 2,785 acceptable beds for tuberculosis. On this basis, there is a need for 4,318 additional beds.

HOSPITAL ADVISORY COUNCIL

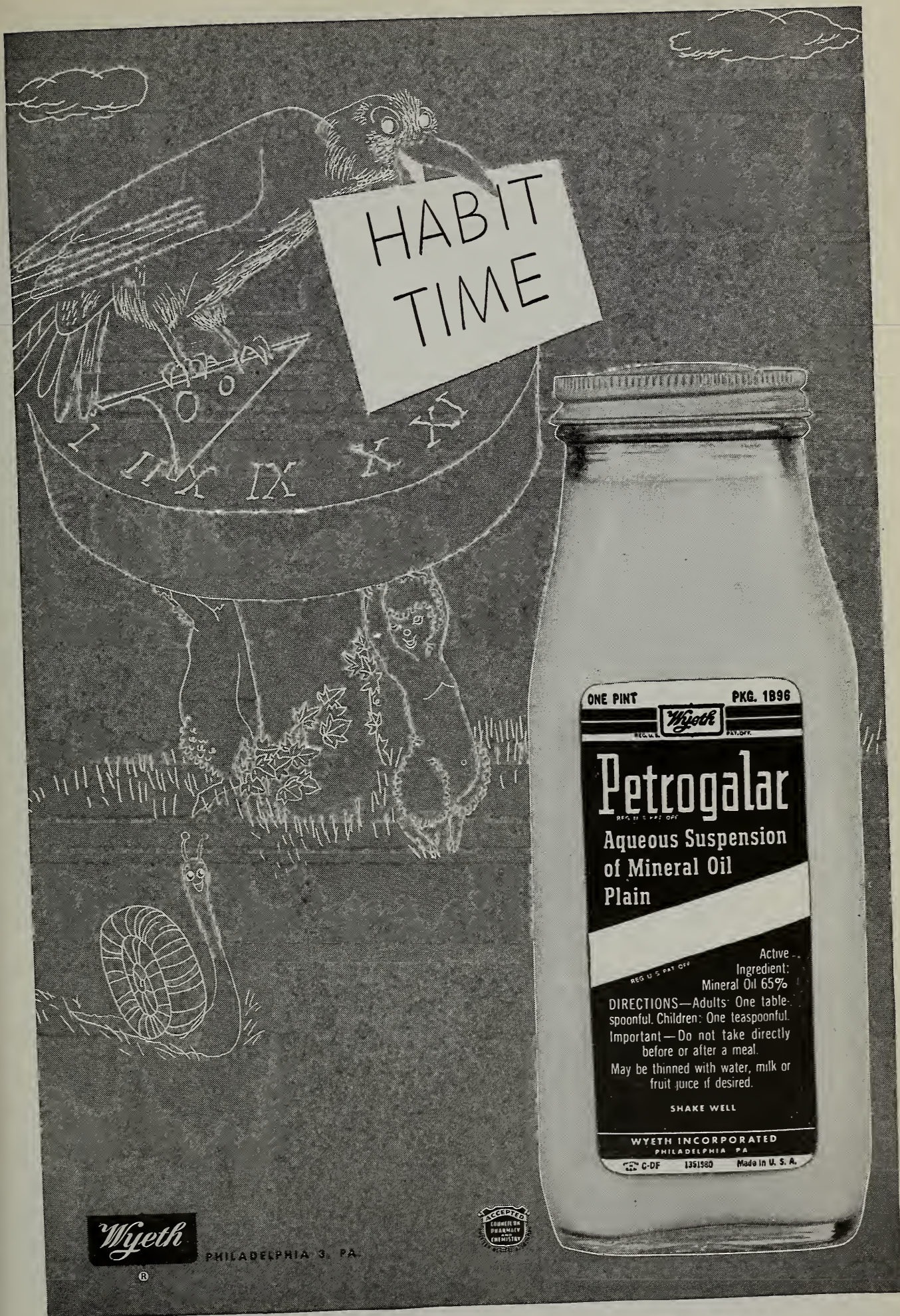
The Hospital Advisory Council consists of the following: Ex officio chairman, Dr. Porterfield; ex officio member, Charles L. Sherwood, director, Department of Public Welfare.

Field of hospital administration—Dr. M. F. Steele, superintendent, Christ Hospital, Cincinnati, tenure of 1 year; W. L. Benfer, superintendent, The Toledo Hospital, 2 years; R. M. Porter, administrator, Children's Hospital, Columbus, 3 years; and Guy J. Clark, executive secretary, The Cleveland Hospital Council, 4 years.

Fields of nursing, welfare, public health, architecture, or allied fields—Msgr. Robert A. Maher, director, Department of Health and Hospitals, Catholic Diocese of Toledo, 1 year; Charles S. Nelson, executive secretary, The Ohio State Medical Association, Columbus, 2 years; Charles F. Owsley, architect, Youngstown, 3 years; and Miss Mabel Selin, R. N., nurse educator, administrator, Magruder Memorial Hospital, Port Clinton, 4 years.

Consumers of hospital services—Miss Doris G. Chandler, executive secretary, Metropolitan Health Council of Dayton and Montgomery County, 1 year; Artee Fleming, attorney, president of the Akron Frontiers Club and a member of the Board of Directors of Akron Community Center, 2 years; Harry W. Culbreth, organization director, Ohio Farm Bureau Federation, Columbus, 3 years; and Joseph W. Fichter, Master, Ohio State Grange, Columbus, 4 years.

Field of medicine and surgery—Dr. Edward J. Humphreys, acting chief, Division of Mental Hygiene, State Department of Public Welfare, Columbus, 1 year; Dr. George A. Woodhouse, Pleasant Hill, 2 years; Dr. Ralph L. Rutledge, president, The Ohio State Medical Association, Alliance, 3 years; and Dr. Joseph B. Stocklen, controller of tuberculosis for Cuyahoga County, Cleveland, 4 years.



In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

CHECKING UP ON WASHINGTON

With the Marshall Plan hearings, the budget, and tax reduction bill occupying the spotlight, sponsors of proposed medical and health legislation are finding little, if any, interest in their measures among most members of Congress. However, a few items and events of interest can be reported.

President Truman has asked Federal Security Administrator Ewing to initiate a study of how health levels can be raised during the next decade . . . an effort, probably, to keep the subject of a national health program alive as election day approaches . . . and doubtless recognition that such legislation . . . even the Taft bill . . . has a mighty slim chance of favorable action at this session of Congress.

Hearings on S. 1320 (Wagner-Murray-Dingell Bill) and S. 545 (Taft Bill) were recessed until March 1. . . both pros and cons willing to give odds that nothing will happen this year on either measure . . . S. 140, the highly controversial bill to establish a Department of Health, Education, and Security, . . . opposed by medical profession as it would put health and medicine in a subordinate position . . . has been blocked several times from a vote on the Senate floor . . . Chances for early consideration of various school health measures unlikely . . . Short-of-breath members of Congress are showing interest in H. R. 5087 and H. R. 5159, both of which call for setting up a National Heart Institute, to conduct research in heart disease and launch activities in that field . . . Proposal to provide more Federal aid to local health departments still in the drafting stage.

Security Administrator Ewing reported to be seeking the cooperation and friendship of A.M.A. on health questions . . . but still continues to plug for Truman's health plan, which includes compulsory sickness insurance system . . . Congressman Harness, according to *Washington Report on the Medical Sciences*, is continuing his campaign against U. S. bureaucrats who have been lobbying for compulsory sickness insurance plan.

Trouble which Uncle Sam is having in retaining top scientists due to competition of private agencies which offer higher pay, proves again that the uncertainties of jobs based on political whims and fancies make it impossible for government to compete with private enterprise . . .

or to maintain equal standards . . . War Assets Administration, which may be liquidated by June, said to be offering some real bargains to non-profit agencies . . . including hospitals . . . even offering to give away some materials.

SPEAKERS BUREAU DIRECTORY FILLING THE BILL

Recently the secretary of a County Medical Society sent a note to the Columbus Office, expressing appreciation for the fine address made to the society by one of the speakers listed in the Speakers Bureau Directory of the State Association.

"Addresses such as his are a great boon to our rural county societies", he stated.

All of which goes to show that the excuse which some county societies are using for not holding meetings, namely "we can't have a program", is not a valid excuse. By using the Speakers Bureau Directory, almost any County Society can have a meeting and a good program. If the society is small, it might well consider joining, for purposes of a meeting, with one or several nearby societies, using the Directory for speaking talent.

MAGNUSON'S GOAL O. K., BUT HIS TACTICS POOR

According to Dr. Paul Magnuson, new medical director of the Veterans Administration, the V.A. is going to crack down on "chiseling" physicians. He said names, places, and dates would be turned over to the A.M.A. for disciplinary action, indicating that the list is not a long one as "there are very few real chiselers in our profession".

We have no quarrel with Dr. Magnuson about his objective. The overwhelming number of ethical, honest members of the medical profession would like to see the "bad boys" spanked good and hard. If proper evidence is submitted, there is every reason to believe that medical societies will do everything within their power to discipline the chiselers.

On the other hand it is too bad that Dr. Magnuson popped off so suddenly, which seems to be a habit on the part of too many physicians holding administrative positions in the V.A. and elsewhere.

It would have been far better if he had conferred with officials of the A.M.A. and had his representatives confer with officials of various state medical societies before making the head-

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lines. The judicious thing for him to have done would have been merely to hand the names of the "chisellers" with supporting evidence to the medical societies, requesting them to act.

Instead he saw fit to furnish material for glaring headlines in the press, making it appear as if most physicians are "skunks", as he termed it.

By being untactful, Magnuson has put the profession on the defensive whereas he could have won the active support of the thousands of "good boys" by handling the situation diplomatically.

In the final analysis, we smell a wee bit of passing the buck. The V.A. has control of authorizations and sets the fees which seem to us to give them plenty of authority to dispose of the chisellers if the occasion demands. Moreover, one might ask Dr. Magnuson what, if anything, is being done to see that the ethical doctors get paid more quickly and what if anything is being done to strip the V.A. procedure of some of the unnecessary red tape which remains as a hang-over from the old days?

So far as Ohio is concerned, we are of the opinion the medical societies will support Dr. Magnuson in his objective, providing of course, sound evidence is presented. But, we don't believe that the physicians of Ohio, the great majority of whom are honest and ethical, will go for any more of the headline stuff such as he dished out in his maiden interview.

GOVERNORS WANT NO PART OF S. 1320

Several months ago Senator H. Alexander Smith, New Jersey, chairman of the Sub-Committee on Health, U. S. Senate Committee on Labor and Public Welfare, polled the governors of all states as to whether in their opinion their states would favor S. 1320, the so-called Wagner-Murray-Dingell compulsory health insurance bill, or S. 545, the so-called Taft National Health Bill, providing for Federal aid to states to work out their own health programs.

On January 27, Senator Smith made public an analysis of the replies received.

Twenty-six states (including Ohio) expressed a preference for S. 545, with or without qualifications; eight states indicated no preference; five states indicated they were not in favor of either bill; and nine states failed to reply.

This analysis may be of considerable help to Congress in determining what action, if any, should be taken by the Federal Government on health legislation. As Senator Smith said to Senator Murray, Montana, when Murray accused Smith of by-passing the people: "The people elect the governors."

THE RECORD SPEAKS CONCERNING N.P.C. AND A.A.P.S.

During the past few weeks, the Columbus Office has had inquiries from a few members regarding the policy of the Ohio State Medical Association with respect to the National Physicians Committee and the American Association of Physicians and Surgeons. What is news to one member, may be news to many. Therefore, for the information of all members, the following comments are presented:

The Ohio State Medical Association (meaning The Council and the House of Delegates, the governing, policy-making bodies) has endorsed neither the National Physicians Committee nor the American Association of Physicians and Surgeons.

At the 1944 Annual Meeting of the Association, the House of Delegates adopted a resolution reading in part as follows: "That the Ohio State Medical Association express itself as believing that the American Medical Association is the proper organization to represent the medical profession of this country on legislative matters and questions pertaining to health and medical activities of all departments and agencies of the Federal Government, as well as similar activities of national unofficial and voluntary groups and organizations."

In a statement adopted on January 14, 1945, The Council stated that "there is no necessity for the formation and maintenance of independent organizations to carry on these activities (i.e., legislative and public relations activities) for the medical profession".

Some months ago "The Observer", the editorial writer of *The Medical Annals of the District of Columbia*, official magazine of the Medical Society of the District of Columbia, commenting about the confusion which exists in the public's mind and in the minds of Federal officials and members of Congress as to just what organization does speak officially for the medical profession, offered this observation:

"The truth of the matter is that there are too many spokesmen for the medical profession in Washington. There are also too many organizations 'bulletining' physicians—or rather briefing physicians on what they should do to stop the inroads of 'socialized medicine'.

"It is high time that doctors in this country realize that the American Medical Association is most adequately represented in the Nation's Capital by Dr. Lawrence; that the A.M.A. also has an excellent department handling legal and legislative matters in Chicago, of which Mr. J. W. Holloway is the able head. This department works hand in hand with the Washington office. Other medical organizations with the same point of view, if their supporters believe them to be essential, should rely upon the

Experience is the Best Teacher

It's true in medicine—

**John William
Ballantyne**
(1861-1923)

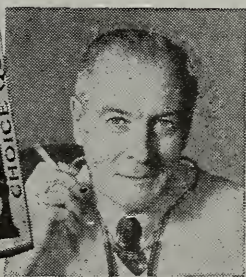
*proved it in
obstetrics*



BALLANTYNE, in his early studies of anatomical and pathological conditions found in the new-born, sensed the value of routine prenatal care in obstetrics. As a pioneer for prenatal care he was the first to establish a clinic for the expectant mother. World-wide acceptance of Ballantyne's concepts quickly followed his successful experiences in prenatal supervision.

*Experience is the best
teacher in choosing
a cigarette, too!*

**MORE PEOPLE ARE SMOKING CAMELS
THAN EVER BEFORE!**



Yes, experience is the best teacher in choosing a cigarette. Millions of smokers who have tried and compared different brands have found that Camels suit them best. As a result, more and more people are smoking Camels as the "choice of experience."

Try Camels. See if your own taste doesn't appreciate the rich, full flavor of Camels. See if your own throat doesn't welcome Camel's cool mildness.

Let your own experience tell you why more people are smoking Camels than ever before.

According to a Nationwide survey:

***More Doctors Smoke CAMELS
than any other cigarette***

When 113,597 doctors from coast to coast — in every field of medicine — were asked by three independent research organizations to name the cigarette they smoked, more doctors named Camel than any other brand!

A.M.A.'s leadership in legislative matters, allowing them to 'carry the ball'. To do otherwise is just not good sense, and may jeopardize organized medicine's position."

That observation and warning came from a well-informed person on the firing line at Washington.

A little deduction would indicate that since the medical profession can rely on the A.M.A. representatives because they are "carrying the ball" and can rely on representatives of the various state and county medical societies to do their part, because they too are "carrying the ball" (Ohio being an example) then there can be little, if any, necessity for the formation and maintenance of independent organizations, as The Council said on January 14, 1945.

If there are those in Ohio who believe the Ohio State Medical Association and its component societies are letting them down by not properly representing and protecting their interests, it is time for them to make this known to The Council and the House of Delegates. These bodies have the authority, and we are sure, the courage, to correct the situation, if it exists.

SOMETHING TO WRITE YOUR CONGRESSMAN ABOUT—NOW

These things Congress should be told, states the Ohio Chamber of Commerce in a special bulletin to its members:

1. That the over-all expenditures of the Federal Government must be sharply reduced, and at once;
2. That it is economically unsound and dangerous to use the Marshall Plan to over-export, thereby maintaining or aggravating shortages of goods critically needed in this country, increasing inflationary pressures;
3. That the essential needs both of the Marshall Plan and for maintaining an adequate national defense, can be met within the limits of a reduced budget;
4. That the confiscatory wartime tax rates imposed on the middle and upper bracket taxpayers must be relieved now, if the competitive private enterprise system is not to be crippled in its recovery and needed expansions.

Has the medical profession been caught in the tenacles of inflation?

Doctor, you figure that out for yourself.

If you come up with the kind of answer we think you will, then isn't it about time for you to let your Congressman and Ohio's Senators know that you want something done to stabilize the nation's economy, along the lines suggested above?

This is the business of the medical profession

as much as the business of the industrialist, grocer, meat dealer, shoe store owner, etc.

All the promises which a good many members of Congress are making to reduce expenditures and cut the tax burden won't amount to a thing unless enough persons let them know that they are for just that.

ARE YOU PREPARED TO VOTE ON MAY 4?

What do you know about the candidates for public office, including the Ohio General Assembly and the U. S. Congress, seeking nomination in the primary elections to be held on May 4?

Better get busy and find out about them. Get the legislative committee of your County Medical Society to find out for you.

Are you qualified to vote in the primary elections?

Better find out. In these times no citizen can run the risk of losing an opportunity to vote.

Have you jotted down the date—May 4—so you won't forget to vote?

The time to begin picking those you want to represent you in public office is at the primary elections.

The person who passes up a chance to aid in nominating and electing good men and women for public office is a chump.

To be more specific: Doctor, what interest are you showing in this vital matter? The stakes are going to be pretty high and the outcome of this year's elections—in May and in November—of great importance. Better get busy.

SKILL REQUIRED TO GIVE NEW CANCER TEST

The Papanicolaou test for uterine cancer has been receiving widespread publicity in the lay press. As might be supposed, as a result of this publicity, many physicians are being asked by their patients for this test.

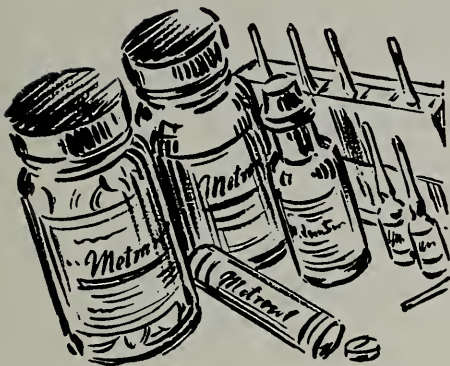
That it would be dangerous for physicians to go off half-cocked in using this procedure is emphasized in an editorial published in the January 31 issue of *The Journal of the A.M.A.* The article implies that special training to secure and to examine the specimen is required, and that indiscriminate use of the test will result in more harm than good. In other words, although the test is being recognized as a valuable diagnostic aid, it must be done properly by skilled persons. The present list of those possessing that skill is not lengthy.

Attempts in Congress to socialize medical practice are typical of methods being used in America to undermine free private enterprise, J. C. Penney, founder and honorary chairman of the J. C. Penney Company, declared in a recent address before Toledo Post, American Legion.

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Dr. Volpe Named V.A. Tri-State Medical Director

Dr. Peter A. Volpe, Worthington, has been appointed medical director for the Veterans Administration in Ohio, Michigan, and Kentucky. He has been chief of physical medicine rehabilitation for the V.A. in the three states since August, 1946, and has been acting medical director since last September. In addition, he will continue to supervise the physical medicine rehabilitation program.



DR. VOLPE

A native of Columbus and a graduate of Ohio State University College of Medicine in 1931, Dr. Volpe was engaged in private practice in Columbus until he entered the service September, 1942. He was a major in the Army Medical Corps and was wounded while on active duty in Germany.

Dr. Volpe is a member of the Columbus Academy of Medicine, the Ohio State Medical Association, the National Rehabilitation Association, the

American Congress of Physical Medicine, and the American Legion. He and Mrs. Volpe have two children.

Nursing Chief Takes Course

Miss Frances M. Hellman, chief of the Veterans Administration Nursing Division in Ohio, Michigan, and Kentucky, left Columbus Jan. 17 for Washington, D. C., to engage in part-time work in the V.A.'s General Office and to attend a course in hospital administration at Catholic Hospital. Miss Helen Kitzerow, assistant chief, will be in charge during her absence.

Pharmacy Chief Named

E. Burns Geiger has been appointed chief of the Pharmacy Division of the Veterans Administration Department of Medicine and Surgery. Before his new assignment, he was assistant to the former chief of the Division.

Dr. Jose P. Bantug, chief of the Division of Health Education and Information of the Philippines, is in Cleveland for two months to study the Cleveland Health Museum. He expects to establish a similar museum in Manila upon his return.



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In Memoriam

Robert Bruce Bainter, M. D., Zanesville; Baltimore Medical College, 1893; aged 81; died Jan. 20; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Bainter also studied at the Starling Medical School, Columbus, and took postgraduate work at Western Reserve University School of Medicine. After practicing medicine at Coshoc-ton, he went to Zanesville in 1904. For several years he was chief of staff at Bethesda Hospital. Surviving are his widow, a sister and two brothers. Among surviving nieces and nephews is Dr. Margaret O'Neal also of Zanesville. He was a member of the Lutheran Church, the Masonic Lodge, Exchange Club, and Modern Woodmen.

William Henry Burns, M. D., Alliance; Cleveland-Pulte Medical College, 1902; aged 67; died Jan. 20; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Burns practiced medicine in Alliance since 1902. For many years he served as health commissioner of Alliance, and for eight years was on the health board. He was a member of the Methodist Church and of Phi Alpha Gamma fraternity. His widow and a brother survive.

Charles Wilson Conley, M. D., Columbus; Eclectic Medical College, Cincinnati, 1895, and Rush Medical College, 1898; aged 81; died Jan. 28; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Conley practiced medicine for 53 years. Before going to Columbus in 1923, he practiced in the vicinity of Eaton. He belonged to the Masonic Lodge. Surviving are a son, Dr. Lowry C. M. Conley of Detroit, two sisters and a brother.

Edmund H. Hedges, M. D., Lima; St. Louis University School of Medicine, 1918; aged 53; died Feb. 11; member of the Ohio State Medical Association and the American Medical Association; a Fellow of the American College of Surgeons and of the American Urological Society; and a Diplomate of the American Board of Urology. Dr. Hedges moved to Lima in 1920 and practiced medicine there since. He was an active staff member of St. Rita's and Lima Memorial Hospitals.

Ralph David Herlinger, M. D., Warren; Johns Hopkins University School of Medicine, 1919; aged 55; died Feb. 2; member of the Ohio State Medical Association, a Fellow of the American Medical Association, and a Fellow of the American College of Surgeons. He was vice-president of the Trumbull County Medical So-

ciety in 1929 and president in 1930. He was a delegate of his society in 1930 and from 1933 through 1947; was on the Legislative Committee in 1932 and from 1935 through 1944; and was secretary of the society in 1944. Dr. Herlinger served in the Medical Corps during World War I and practiced medicine in Warren since 1922. He was a member of the Presbyterian Church, the Masonic Lodge, the American Legion and other fraternal orders. Surviving are his father and three sisters.

Guilford Bert Hoiston, M. D., Columbus; Ohio State University College of Medicine, 1938; aged 37; died Jan. 14; member of the Ohio State Medical Association and the American Medical Association. Dr. Hoiston served for a year in the C. C. C. and later served as staff physician at the Ohio State Penitentiary. In 1940 he was discharged from the Army Medical Corps with the rank of major, and began practice in Columbus. He was a member of the Baptist Church, the Masonic Lodge, the American Legion and many other organizations. His widow, two sisters and a brother survive.

Roy Sterling Hubbs, M. D., Butler; Pulte Medical College, Cincinnati, 1896; aged 73; died Jan. 16. Dr. Hubbs was actively engaged in the practice of medicine in Butler and vicinity since 1897. Surviving are his widow, one son, a sister and a brother.

John Wesley Hutchins, M. D., Sciotoville; Miami Medical College, Cincinnati, 1905; aged 64; died Jan. 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Hutchins practiced medicine in Scioto County since 1905, and was active in the civic, political, business and sports life of the community. He was a member of the Masonic Lodge and the Order of Elks, and was on the physicians' and surgeons' staff of the Norfolk & Western, Chesapeake & Ohio, and Baltimore & Ohio Railways. He is survived by his widow and a son.

Azro John Pardee M. D., Ashtabula; Cleveland-Pulte Medical College, 1912; aged 62; died Jan. 18; member of the Ohio State Medical Association and Fellow of the American Medical Association; president of the Ashtabula County Medical Society in 1929 and 1930. Dr. Pardee practiced medicine for 35 years chiefly in Ashtabula. During World War I he served overseas in the Army Medical Corps. Surviving are a son, a daughter and a half-brother.

Joseph Bennedick Metzger, M. D., Toledo; Ohio State University College of Medicine, 1915;

aged 64; died Jan. 24; former member of the Ohio State Medical Association and the American Medical Association through 1937. Dr. Metzger practiced medicine in Toledo since 1916. He was a member of the staff at St. Vincent's Hospital and physician for the Toledo Lodge of Eagles. Surviving are his widow and a sister.

William W. Scarborough, M. D., West Farmington; Baltimore Medical College, 1901; aged 73; died Jan. 28. Dr. Scarborough practiced medicine in Mount Vernon and Cleveland before his retirement in 1940. Surviving are his widow and a sister.

Arthur Bushnell Smith, M. D., LaJolla, Calif.; Cleveland University of Medicine and Surgery, 1897; aged 74; died Jan. 11; former member of the Ohio State Medical Association and the American Medical Association; Diplomate of the American Board of Radiology; member of the Radiological Society of North America, Inc., and the American College of Radiology. Dr. Smith practiced medicine in Wellington, Elyria, and Cleveland before moving to California 20 years ago. His widow survives.

William H. Thompson, M. D., Cleveland; Cleveland University of Medicine and Surgery, 1880; aged 97; died Jan. 16. Dr. Thompson practiced medicine principally in Cleveland until his retirement 25 years ago. He was a member of the Masonic Lodge. Surviving are his widow and three grandchildren.

George Frederick Zininger, M. D., Canton; Starling Medical College, Columbus, 1892; aged 80; died Jan. 28; former member of the Ohio State Medical Association and Fellow of the American Medical Association; a delegate of the Stark County Medical Society in 1923-24 and 1938-39. After receiving his medical degree, Dr. Zininger practiced for a while in Stark County, took postgraduate work at Johns Hopkins University. He returned to his native county where he practiced until his retirement a few years ago. He was a member of the Lutheran Church. Dr. Zininger is survived by his widow, three daughters, including Dr. Pauline Zininger of Canton, and a son, Dr. Max M. Zininger of Cincinnati.

Josiah Lilly Dies

Josiah Kirby Lilly, chairman of the board of directors of Eli Lilly and Co., Indianapolis, died on Feb. 8 at the age of 86. He was the son of Colonel Eli Lilly who founded the company in 1876. Josiah Lilly became president of the company upon the death of his father in 1898 and in 1932 was elected chairman of the board. He retired from active service in 1945.



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*Barr, Joseph S., *Ruptured Intervertebral Disc and Sciatic Pain*, Jr. Bone and Joint Surg., 29: 429-437 (April) 1947.

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Buckeye News Notes

Columbus—Appointment of Dr. Lovell W. Rohr as a member of the City Board of Health to succeed the late Dr. Chester O. Cramer was announced early in January. Dr. Rohr served as an Army Medical Corps major in World War II and also is a veteran of World War I.

Elyria—Dr. Joseph M. Strong addressed the 18th annual Lorain County Industrial Safety Campaign Conference in January. He discussed common back disabilities and their relationship to industrial employment.

Hillsboro—Thirteen physicians were appointed early in January on the first medical staff of the Hillsboro Hospital. At an organization meeting, the following officers, all of Hillsboro, were elected: Dr. W. B. Roads, chairman; Dr. C. G. Floor, vice-chairman; Dr. Leland D. McBride, secretary; and Dr. Lena B. M. Holladay, treasurer.

Jefferson—Dr. C. C. Crosby, Ashtabula County health commissioner since 1940, announced his resignation effective Feb. 2.

Millersburg—Dr. N. P. Stauffer was re-elected president of the Holmes County Board of Health in January.

Portsmouth—Dr. E. J. Humphreys, Columbus, Acting State Commissioner of Mental Hygiene, spoke at a January meeting of the local mental hygiene committee.

Ravenna—Guest speaker at a January meeting of the DePeyster School Parent-Teacher Association was Dr. John M. Painter of Kent. His topic was "School Health Problems".

Sandusky—"The Importance of Palestine's Role in American Politics", was the subject of a talk given by Dr. Ernst Speyer before a January meeting of the Women's Civic Club.

St. Marys—The shortage of general practitioners and nurses in St. Marys and similar communities was deplored by Dr. Guy E. Noble in a recent talk before the Parent-Teachers Association. Young doctors are specializing and going to cities where there are hospitals, he said. He favored a health program for St. Marys and employment of a health nurse.

Troy—Dr. G. J. Hance was reappointed as a member of the Troy Board of Health for another five-year term. He has served on the board since 1920.

Youngstown—Dr. M. P. Mahrer, who paints and sculptures as a hobby, conducted a tour of water colors in the 13th Annual New Year Show at Butler Art Institute early in January. Dr. Mahrer is a member of the American Physicians Art Association, and is active in other groups. He has exhibited his work throughout the country and has visited many art galleries in Europe.

for March, 1948



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, *Amer. J. Clin. Pathology*, 14:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, *J. Amer. Med. Tech.*, 8:606-14 (Sept.) 1947.

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Pediatricians To Meet

An area meeting of the American Academy of Pediatrics will be held at the Hotel Statler, Buffalo, N. Y., April 29-May 2. Members of state medical societies are welcome. Registration may be made ahead of time by writing to Dr. C. G. Grulec, secretary-treasurer, 636 Church St., Evanston, Ill., enclosing a check for \$10, or registration may be made at time of the meeting.

General Practitioners To Meet In Cincinnati

All doctors doing general practice are invited to attend a meeting of the Ohio Academy of General Practice at 9 p. m., March 30, in the Netherland Plaza, during the annual meeting of the Ohio State Medical Association. The meeting will be for the adoption of the state constitution and by-laws, and for membership enrollment. Parlors E and F will be reserved for the conference.

National Heart Disease Control Sought in Two House Bills

Two similar bills to provide for research and control relating to diseases of the heart and circulation were introduced in the House of Representatives in January from opposite extremities of the country.

On Jan. 21, Mr. Keefe of Wisconsin introduced a bill which would provide for the development of a National Heart Institute, patterned over the National Cancer Institute, for the purpose of research, investigations, experiments, and demonstrations relating to the cause, prevention, methods of diagnosis, and treatment of heart diseases.

Mr. Smathers of Florida introduced a similar bill on Jan. 27. Both have been referred to the Committee on Interstate and Foreign Commerce.

Courses For Technologists

The week of March 22 has been set aside by the University Hospital of The Ohio State University for refresher courses in laboratory techniques for registered medical technologists under direction of Dr. H. L. Reinhart, director of clinical laboratories at the hospital.

These courses are designed for critical analysis of all laboratory techniques as well as the mastering of newer techniques which have proved of value in the diagnosis of disease. Information may be obtained by writing Dr. Reinhart.

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ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting April 12, May 10, June 7.

Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting March 29, April 26, May 24.

Surgical Anatomy and Clinical Surgery, two weeks, starting April 12, May 10.

Surgery of Colon and Rectum, one week, starting April 26, May 24.

Surgical Pathology every two weeks.

FRACTURES AND TRAUMATIC SURGERY—Intensive Course, two weeks, starting June 7.

PEDIATRICS—Intensive Course, four weeks, starting April 5.

GYNECOLOGY—Intensive Course, two weeks, starting April 26, June 7.

OBSTETRICS—Intensive Course, two weeks, starting April 12, June 21.

MEDICINE—Intensive Course, two weeks, starting April 26.

Personal Course in Gastroscopy, two weeks, starting March 29, April 19.

Electrocardiography and Heart Disease, four weeks, starting May 3.

DERMATOLOGY—Formal Course, two weeks, starting April 26.

Clinical Course every two weeks.

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Society for Crippled To Promote Sale of Easter Seals

The accompanying illustration is that of the Easter Seal which will be distributed across the nation for the benefit of crippled children and adults from Feb. 28 through March 28. The



seal will be distributed in Ohio for the 13th consecutive year by The Ohio Society for Crippled Children and 75 affiliated county societies and cooperating service clubs. Their goal is \$350,000 to be distributed as follows: 75 per cent to local groups after a deduction of 8.3 per cent for the program of the National Society for Crippled Children and Adults; the balance to be used for the work of The Ohio Society.

New Schering Representative

Schering Corporation of Bloomfield and Union, New Jersey, has appointed as Ohio representative, Edward J. Zeller, Defiance, whose headquarters will be in Toledo. Mr. Zeller graduated from Defiance College and also attended Ohio State University and the Western Reserve University, majoring in scientific studies at both schools.

Income Tax Returns

For up-to-date information on the filing of Federal income tax returns refer to pages 173-177 of the February issue of *The Ohio State Medical Journal*. Inasmuch as there have been no changes in the Federal income tax law, and since no changes are anticipated by March 15, the general procedures which were followed last year will be applicable this year.

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Do You Know? . . .

There are now 74 full-time public health units in Ohio, compared with 51 in 1942. Units served by part-time health commissioners number 92.

* * *

Dr. Walter M. Solomon, Cleveland, was one of the speakers at a one-day seminar on physical medicine at Bay City, Mich., Feb. 4. His subject was "Physical Medicine in Arthritis".

* * *

The 1948 officers of the Central Ohio Academy of Pharmacy were installed by Dr. Harve M. Clodfelter, President of the Columbus Academy of Medicine, and Councilor for the Tenth District of the Ohio State Medical Association.

* * *

Speakers at the Annual Clinical Conference of the Chicago Medical Society, March 2-5, at the Palmer House, include Dr. Charles C. Higgins, Cleveland, whose subject is "Management of Patients with Renal Lithiasis".

* * *

"The Program of the Council on National Emergency Medical Service of the American Medical Association" was discussed by Dr. Richard L. Meiling, Columbus, secretary of the Council at the annual Secretaries' Conference of the Indiana State Medical Association, February 15, at Indianapolis.

* * *

Dr. Lester G. Parker, Sandusky, founder of the local Amvets Community Blood Bank, received a distinguished service award from the Junior Chamber of Commerce for making the most outstanding contribution to the city's welfare last year.

* * *

Modern hospitalization and prepaid medical service plans on a voluntary basis are based on sound insurance principles and furnish the best method of financing medical and hospital bills, Bishop Karl J. Alter, Toledo, said at the recent 30th annual banquet of the Mercy Hospital medical staff.

* * *

Dr. L. C. Hatch, Akron, is the new medical director of the Goodyear Tire & Rubber Co. He is responsible for direction of medical policies for all Goodyear operations.

* * *

Dr. I. Arthur Mirsky, director of The May Institute for Medical Research, Cincinnati, gave two lectures in Omaha, Nebraska, Feb. 11. He spoke at an afternoon meeting of professional personnel at the University of Nebraska College of Medicine on the topic "Is It Normal?"; and addressed a public meeting in the evening on "The Biology of Metabolic Disease in Man".

A list of medical motion pictures which the American Medical Association has available on a loan basis for medical groups can be obtained by writing to Ralph P. Creer, Secretary, Committee on Medical Motion Pictures, A.M.A., 535 N. Dearborn St., Chicago 10, Ill.

* * *

Charles S. Nelson, executive secretary of the Ohio State Medical Association, participated in a 15-minute round-table radio discussion, Wednesday afternoon, Feb. 4, over WRFD, Worthington, on the subject "Can Our County Public Health Program Be Improved?" Other discussants were Mrs. Ada Smith, Chairman of the Franklin County Rural Health Committee, and D. R. Stanfield, legislative director, Ohio Farm Bureau.

* * *

The program of the medical profession for better distribution of medical care and medical and health legislation pending in the U. S. Congress were discussed by George H. Saville, director of public relations, Ohio State Medical Association, at a meeting of the Canton Rotary Club, Feb. 13.

* * *

As the oldest living graduate of Ohio Wesleyan University, Dr. Edwin W. Mitchell, 93-year-old Cincinnati physician, has the distinction of carrying the cane of William D. Godman, the first Ohio Wesleyan graduate. Dr. Mitchell retired two years ago after 63 years of active practice in Cincinnati.

* * *

Dr. Jonathan Forman, editor of *The Ohio State Medical Journal*, and Charles S. Nelson, the executive secretary of the Ohio State Medical Association, were guest speakers at the annual banquet of the Chamber of Commerce of Upper Sandusky on the evening of January 29. The service clubs of the city and the Wyandot County Medical Society were guests for the evening.

* * *

Dr. Morris Fishbein and Dr. Thomas G. Hull of the American Medical Association recently were appointed members of the Committee on Exhibits for the First International Poliomyelitis Conference to be held at the Waldorf-Astoria in New York, July 12-17, under auspices of the National Foundation for Infantile Paralysis.

* * *

Announcement has been made of the appointment of Dr. Edgar van Nuys Allen, formerly of the Mayo Clinic, as chief of the Division of Internal Medicine at the Cleveland Clinic.

Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BROWN

The Brown County Medical Society elected the following officers for the year: Dr. R. B. Hannah, Georgetown, president; Dr. W. L. Faul, Georgetown, vice-pres.; and Dr. George P. Tyler, Jr., Ripley, secretary.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

"Recent Advances in the Diagnosis and Treatment of Coronary Thrombosis and Myocardial Infarction", was the topic of a discussion by Dr. Johnson McGuire of Cincinnati at the January scientific meeting of the Clark County Medical Society, in the Nurses Residence of Springfield City Hospital. At the regular scientific meeting on Feb. 16, Dr. Oscar F. Rosenow of Columbus, addressed the society on the subject, "Diagnostic Points in Medicine".

MIAMI

Dr. Jerry Price of New York City, consultant for the Ohio Society of Crippled Children, spoke on the subject, "Epilepsy", at the Feb. 13 meeting of the Miami County Medical Society. The secretary, Dr. G. A. Woodhouse, a member of the Ohio State Department of Health, Hospital Advisory Commission, gave a report of the activities of that commission in relation to the Hill-Furton Law.

MONTGOMERY

Attorney Hugh Altick addressed the Montgomery County Medical Society on Jan. 18 on, "Legal Aspects of Medicine". The meeting was held in the Miami Hotel, Dayton.

PREBLE

Dr. E. P. Trittschuh, Lewisburg, became president of the Preble County Medical Society for 1948. Other officers selected include: Dr. C. E. McKinley, Camden, pres.-elect; Dr. Dale Kessler, Camden, secy.-treas.; and Dr. C. E. Newbold and Dr. J. R. Williams, both of Eaton, delegate and alternate respectively.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

ALIEN

Guest speaker at the Jan. 20 meeting of the Academy of Medicine of Lima and Allen County was Dr. Joseph Hayman, of Western Reserve University.

MARION

Newly-elected president of the Marion County Academy of Medicine is Dr. J. W. Bull. Other officers are Dr. Alston E. Morrison, vice-pres.; and Dr. William H. Whitehead, secy.-treas. All three are residents of Marion.

SENECA

Members of the Seneca County Medical Society selected the following Tiffin physicians as officers for the year: Dr. C. W. Consolo, pres.; Dr. G. H. W. Bruggemann, vice-pres.; Dr. Walter Daniel, secy.-treas.; Dr. R. F. Machamer, delegate; and Dr. P. J. Leahy, alternate. Dr. E. F. Ley was named on the legislative committee.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

HENRY

President of the Henry County Medical Society for 1948 is Dr. B. J. George of Liberty Center. Other officers include, Dr. W. R. Ward, Holgate, vice-pres.; Dr. R. L. Gilson, Napoleon, secy.-treas.; Dr. B. L. Johnson, Deshler, delegate; and Dr. Thomas W. Quinn, Napoleon, alternate.

LUCAS

The Academy of Medicine of Toledo and Lucas County elected the following officers, all residents of Toledo: Dr. Howard Holmes, pres.; Dr. Foster Myers, pres.-elect; Dr. Carl H. Bayha, secy.; and Dr. W. W. Alderdyce, treas.

PAULDING

Members of the Paulding County Medical Society elected the following officers for the year: Dr. G. L. Doster, Paulding, pres.; Dr. R. J. Dilery, Paulding, vice-pres.; Dr. K. C. Evans, Payne, secy.-treas.; Dr. Ray Mouser, Paulding, delegate; and Dr. Evans, alternate.

WILLIAMS

Dr. J. A. Maxwell, Montpelier, was elected president of the Williams County Medical Society for 1948, with the following other officers: Dr. Richard Solier, Bryan, vice-pres.; Dr. P. G. Meckstroth, Bryan, secy.-treas.; and Dr. H. W. Wertz, Montpelier, and Dr. H. R. Mayberry, Bryan, delegate and alternate, respectively.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

Dr. Gerard DeOreo, of Western Reserve University, spoke on the treatment of syphilis with penicillin before the Ashtabula County Medical Society on Jan. 13. The annual dinner dance of the society was held on Feb. 10.

CUYAHOGA

The February program for the Academy of Medicine of Cleveland was as follows:

Feb. 4—Pediatric Section, "Histoplasmosis", by Dr. Amos Christie, Vanderbilt University.

Feb. 6—Clinical and Pathological Section, Presentation of cases under direction of Dr. Russell Haden.

Feb. 13—Experimental Medicine Section (and Cleveland Section of the Society for Experimental Biology and Medicine), "Effect of Alkali Upon Blood Level and Excretion of Salicylates", by Jack R. Leonards, Ph. D., and Florence Williams, Western Reserve University; "Respiratory Acidosis and Alkalosis in Childhood", by Dr. Samuel Spector; "A New Graphic Objective Method of Measuring Systolic Pressure in the Intact Unanesthetized Rat", by Dr. A. C. Corcoran, Dr. I. H. Page, Otto Glaser, Ph. D., and Frederick Olmstead; "The Effect of Low Protein and Low Choline Diets on the Absorption of Iron and Copper", by Dr. T. D. Kinney and Mark Hegstead, Ph. D.

Feb. 18—Industrial Medicine and Orthopedic Section, "Ununited Fractures of the Hip", Dr. Carl E. Badgley, University of Michigan.

LAKE

At a clinical meeting of the Lake County Medical Society on Jan. 23, Dr. Harley Williams of Western Reserve University spoke on "The Treatment of Diabetes".

Following are speakers included on coming programs of the Lake County Medical Society:

March 19—Dr. Charles R. Hughes and Dr. Joe E. Brown of Cleveland, "Treatment of Fractures of Hip".

April 23—Dr. H. A. Lund and Dr. William C. McCally of Cleveland, "Carcinoma of Colon".

May 28—Dr. Gerald Schwarz, Cleveland, "Diagnosis of Constitutional Disease with the Ophthalmoscope".

June 9—Clinical Day at Cleveland Clinic, 8 a. m. to 5 p. m.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

MAHONING

The following Youngstown physicians were elected officers of the Mahoning County Medical Society for the year: Dr. John Noll, pres.; Dr. J. N. McCann, vice-pres.; Dr. V. L. Goodwin, secy.; and Dr. J. K. Herald, treas.; Dr. W. M. Skipp, Dr. E. J. Wenaas, and Dr. G. G. Nelson, delegates; and Dr. I. C. Smith, Dr. W. J. Tims, and Dr. R. E. Odom, alternates.

PORTAGE

Dr. Frank L. Meany of Lakewood spoke on "Plastic Surgery" at the Jan. 15 meeting of the Portage County Medical Society, Robinson Memorial Hospital, Ravenna.

SUMMIT

At the scientific meeting of the Summit County Medical Society on Feb. 3 members heard a talk by Dr. Joseph M. Hayman, Jr., Western Reserve

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University, on "Nephritis, Newer Methods of Treatment".

TRUMBULL

Dr. Regis McNamee of Cleveland addressed a February meeting of The Trumbull County Medical Society on the subject of cancer. On Feb. 19 at a combined meeting with the Woman's Auxiliary, Dr. E. O. Harper of Western Reserve University addressed the group.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

"Management of Early and Latent Syphilis", was the topic of a talk by Dr. Howard T. Phillips of Wheeling, W. Va., before the Belmont County Medical Society at the Bellaire City Hospital on Jan. 19.

JEFFERSON

Newly-elected president of the Jefferson County Medical Society is Dr. John Gallagher of Steubenville. Other officers are: Dr. John Smarrella, Steubenville, vice-pres.; Dr. S. L. Burkhardt, Steubenville, secy.-treas.; Dr. Burkhardt and Dr. Earl Rosenblum, Cincinnati, delegate and alternate, respectively.

TUSCARAWAS

Dr. Philmour M. A. Bein, Mansfield General Hospital, addressed the Tuscarawas County Medical Society at the Central School of New Philadelphia on Jan. 8.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

ATHENS

A discussion on "Infectious Jaundice" was presented by Dr. A. A. Baldwin at the Athens County Medical Society meeting Jan. 13 in the Nelsonville Presbyterian Church.

FAIRFIELD

Dr. R. S. Bode of Rushville was elected president of the Fairfield County Medical Society, with the following Lancaster physicians elected to other offices: Dr. H. M. Amstutz, vice-pres.; Dr. C. W. Brown, secy.-treas.; Dr. L. E. Stenger, delegate; and Dr. C. H. Hamilton, alternate.

GUERNSEY

Advisability of combining the city and county health departments was discussed at the Jan. 15 meeting of the Guernsey County Medical Society at the Berwick Hotel, Cambridge. Dr. Arthur T. Hopwood, superintendent of Cambridge State Hospital, addressed the group on, "Involutional Psychosis".

MUSKINGUM

The Muskingum Academy of Medicine elected the following officers for 1948, all residents of Zanesville: Dr. Lester Lasky, pres.; Dr. William B. Faircloth, vice-pres.; Dr. Beatrice T. Hagen, secy.-treas.; Dr. M. A. Loebell, delegate; and

CHAS. F. BOWEN, M. D.

SPECIALIZES

in

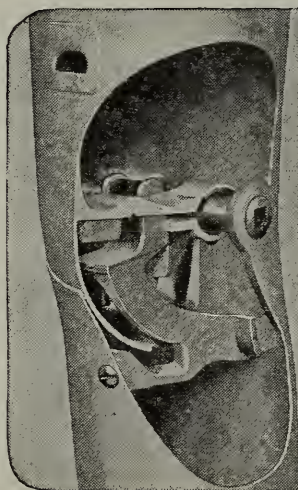
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Dr. C. F. Sisk, alternate. A dinner dance was held by the Academy and the Woman's Auxiliary on Feb. 4 at the University Club, Zanesville.

NOBLE

Caldwell physicians named to offices in the Noble County Medical Society are: Dr. N. S. Reed, pres.; Dr. C. F. Thompson, vice-pres.; and Dr. E. G. Ditch, secy. treas. Dr. Thompson also was named delegate and Dr. Ditch, alternate.

WASHINGTON

Members of the Washington County Medical Society elected the following officers for 1948: Dr. R. M. Meredith, Marietta, pres.; Dr. Richard Rampp, Lowell, vice-pres.; Dr. Donald Williams, Marietta, secy. treas.; Dr. Ford Eddy, Marietta, delegate; and Dr. G. E. Huston, Marietta, alternate.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

MEIGS

Meigs County Medical Society officers for the year are: Dr. William H. Jeric, Pomeroy, pres.; Dr. P. A. Jividen, Rutland, vice-pres.; Dr. Charles J. Mullen, Pomeroy, secy. treas.; Dr. R. E. Boice, Pomeroy, delegate; and Dr. F. M. Cluff, Middleport, alternate.

SCIOTO

The Hempstead Academy of Medicine had as principal speaker at the Feb. 9 meeting Dr. William R. Ferraro who spoke on the subject: "Early Ambulation of Patients".

VINTON

Officers of the Vinton County Medical Society for the year are the following McArthur physicians: Dr. Evelyn Ball, pres.; and Dr. H. D. Chamberlain, secy. treas. Dr. Chamberlain was designated delegate and Dr. Ball, alternate.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

"Renal Circulation and Its Pathology" was the topic of an address by Dr. Joseph Trueta, former dean of the University of Barcelona, Spain, and now lecturer in surgery at Oxford University, England, at a meeting of the Columbus Academy of Medicine and the Columbus Surgical Society, Jan. 23.

"Advances in Chest Surgery" was the topic of an address before the Feb. 2 meeting by Dr. Maurice G. Buckles, formerly of Louisville, Ky., but now of Columbus.

Dr. Russell L. Haden, Cleveland, spoke on "Gout" at the Feb. 16 meeting.

MORROW

Dr. J. P. Ingmire, Mount Gilead, was elected president of the Morrow County Medical Society for the year, with the following other officers: Dr. Lowell Murphy, Cardington, vice-pres.; and Dr. F. M. Hartsook, Cardington, secy. treas.

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Dr. Hartsook was named delegate and Dr. Ingmire, alternate.

UNION

The following officers were elected by the Union County Medical Society: Dr. P. D. Longdrake, Marysville, pres.; Dr. A. M. Johnson, Marysville, secy.-treas.; Dr. E. J. Marsh, Broadway, delegate; and Dr. H. C. Duke, Richwood, alternate.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ERIE

Sandusky physicians named to offices of the Erie County Medical Society are: Dr. E. J. Meckstroth, pres.; Dr. William T. Fenker, vice-pres.; Dr. H. G. Lehrer, secy.-treas.; Dr. V. A. Killoran, delegate; and Dr. Lehner, alternate. At a joint meeting of the society and the Woman's Auxiliary held in Providence Hospital, Sandusky, during January, Dr. A. A. Brindley, of Toledo, president-elect of the Ohio State Medical Association, discussed public relations of the medical profession.

HURON

Members of the Huron County Medical Society elected the following officers: Dr. C. J. Cranston of Wakeman, pres.; Dr. W. A. Drury, Willard, vice-pres.; Dr. George F. Linn, Norwalk, secy.-treas.; Dr. O. J. Nicholson, Norwalk, delegate; and Dr. H. A. Erlenbach, New London, alternate.

LORAIN

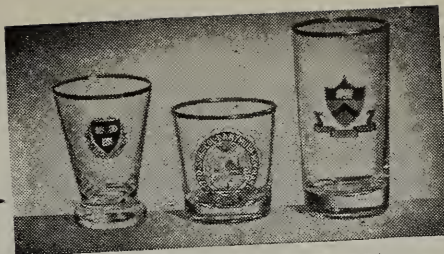
"Coronary Artery Diseases" was the subject of an address by Dr. John P. Anderson, Glenville Hospital, Cleveland, at a Feb. 10 meeting of the Lorain County Medical Society. The meeting was held at the Spring Valley County Club, Elyria.

Northern Tri-State Assn. To Hold 75th Annual Meet

The 75th annual meeting of the Northern Tri-State Medical Association will be held on April 13 beginning at 8:30 a. m. in the High School Auditorium, Findlay, Ohio. Highlight of the program will be a noon luncheon talk by Dr. Roscoe L. Sensenich, South Bend, president-elect of the American Medical Association.

Included on the morning program are the following: "The Depressive Syndrome in General Practice", by Captain G. N. Raines, U. S. N. Medical Corps, Bethesda, Md.; "General Review of Thoracic Surgery", by Dr. Herbert D. Adams, Boston, Mass.; and a Clinical Pathological Conference conducted by Dr. Plinn F. Morse, Detroit, Mich.

On the afternoon program are: Dr. Thomas E. Jones, "Resumé of Surgical Treatment of Peptic Ulcer"; Dr. C. Wesley Eisele, University of Chicago, "Diagnosis and Treatment of Brucellosis"; and Dr. Dallas B. Phemister, University of Chicago, "Treatment of Ununited Fractures".



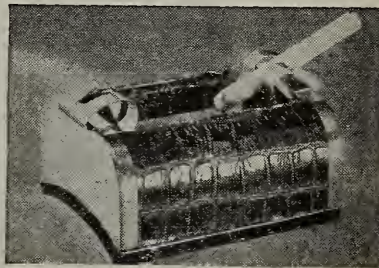
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Woman's Auxiliary News

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

Annual Meeting

The wives of all physicians attending the Annual Meeting of the Ohio State Medical Association are urged to attend both the business sessions and the social functions planned by the Auxiliary.

General Chairman—Mrs. Dale P. Osborn, Cincinnati.

Co-Chairman—Mrs. Paul M. Woodward, Cincinnati.

Auxiliary Headquarters and Registration—Hotel Sinton.

Program

TUESDAY, MARCH 30

9:00 A. M. Pre-Convention Board meeting.

12:30 P. M. Presidents' Luncheon, Ballroom, Hotel Sinton

Address: Mrs. Eustace Allen, Atlanta, Ga., President, Woman's Auxiliary to the A.M.A.

Music

2:45 P. M. Formal opening, House of Delegates
First business session

Presiding—Mrs. Harold K. Mouser, Marion, President.

Adjourn for sightseeing or shopping

WEDNESDAY, MARCH 31

9:15 A. M. Second session of the House of Delegates, Crystal Room, Hotel Sinton

1:00 P. M. Luncheon, honoring President, President-Elect, and Advisory Council of the Ohio State Medical Assn., Ballroom, Hotel Sinton
Speaker—Rev. Laurence H. Hall, "The Therapeutic Value of Laughter"

3:00 P. M. Discussion groups and movies, led by State and Hamilton County Chairmen of Standing Committees.

4:00—6:00 P. M. Tour of Taft Museum. Refreshments

7:30 P. M. Annual Banquet of the Ohio State Medical Association. (Formal dress optional.)

THURSDAY, APRIL 1

8:45 A. M. White Breakfast. "In Memoriam." Ballroom, Hotel Sinton

10:00 A. M. Third session of the House of Delegates, Crystal Room
Adjournment.

1:00 P. M. Post-Convention Board meeting, with luncheon.

* * *

ALLEN

On Tuesday, January 20, the Woman's Auxiliary of Lima and Allen County held an all-day sewing at the home of Mrs. J. R. Tillotson, at which time washable slippers were made for the hospitals. At the business session plans for the

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recruitment of nurses were discussed. It was decided to send out several teams of two, a general speaker and a nurse, to the various high schools in this area. Those interested in nursing will be invited to a hospital for a tour and tea.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

WANTED: Public Health Commissioner in Tuscarawas County, New Philadelphia, Ohio. Must have degree in public health, to serve in county with a population of 40,000; the salary, \$6,600, plus traveling expenses. Write Office of Tuscarawas County Board of Health, New Philadelphia, Ohio.

WANTED—Thoroughly competent physician for Industrial Office. Must be graduate of Class A School with adequate hospital training. Salary \$6,000 per year. Box 16, Ohio State Medical Journal.

DOCTOR, Excellent Opportunity—Will pay subsidy. Modern Home and Office Combined. Office partly equipped. Rent Free. Address Inquiries to Village Clerk, Kelleys Island, Ohio, or Call 261 for appointment.

FOR SALE: Well-established practice; attractive home and office combination in good rural community 25 miles N.E. of Cincinnati; strictly modern; excellent income. Contact A. F. Lippert, M.D., Pleasant Plain, Ohio.

FOR SALE: General practice, combination home and 5-room office in Columbus. Oil heating system. Prof X-Ray; office furniture, equipment, and home furnishings optional. Leaving for specialty training. Box 17, Ohio State Medical Journal.

WANTED: Thoroughly competent physician for locum tenens to begin about March 10 or 15, for one to three months. Salary, \$500 per month. 200 Republic Bldg., Cleveland, Ohio.

WANTED: General practitioner to become associated with a clinic group which is well established. Prefer someone who is interested in the future. Income beginning at \$5,000. Write Box 18, Ohio State Medical Journal.

WANTED: Physician to locate in town of approximately 700 population, in Auglaize County, Ohio. Good school, two churches, telephone exchange, and good surrounding territory. This is a wonderful opportunity for the right party, as there are no other practicing physicians within a 12-mile radius. For information, write or see Russell Bowman, Box B, Waynesfield, Ohio.

WANTED: Locum tenens, Woman Physician in an industrial office, for physical examinations, beginning the latter part of February. 200 Republic Bldg., Cleveland, Ohio.

FOR SALE: 1946 model Beck-Lee electrocardiograph with stand; recently factory serviced; new galvanometer string; also 1 extra bulb and 50 ft. roll of film. Write Box 19, Ohio State Medical Journal.

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WANTED: Physician for locum tenens, May 30 to August 5; busy general practice in Columbus, Ohio; call or write, Dr. L. M. Harris, 685 Bryden Rd.; telephone, Fairfax 6444.

WANTED: Resident Physician at Fort Wayne State School for Mental Defectives, Fort Wayne, Indiana. Medical work mostly general with opportunities in Neuropsychiatry and Pediatrics. Salary \$3,000 plus maintenance; more depending on special qualifications in Psychiatry. Write Superintendent.

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The Physician's Bookshelf

Occupational Medicine and Industrial Hygiene, by Rutherford T. Johnstone, M.D., (\$10.00. C. V. Mosby, St. Louis, Missouri) attempts to tell us that which is concerned with the ecology of the working man. It deals with his working and living habits as well as the physical conditions under which he works and lives. It is interested in the whole man and not his heart, or his allergies, or his eyes alone. The fight is on to make the lives of those who toil worth living. American Medicine is rallying to this concept for it seems to sense the great truth that when we physicians offer and industry accepts an adequate industrial health program, the great mass of American workingmen and their families will never tolerate the political administration and control of their health. Although the author is committed to this viewpoint, the text is limited to his working conditions. It seems too bad that the noonday lunch, the wash room, and the general interest of the plant physician in an education in nutrition and hygiene for the workers' wives do not also get a chapter or two.

The Doctor Discusses Morals, by Winfield Scott Pugh, M.D., (\$1.00 paper. \$1.50 cloth. *The William-Frederick Press, New York City*) presents "the question of morals from the calm, dispassionate viewpoint of the physician, the psychologist, and the anthropologist, rather than from the religio-hysterical viewpoint of the moral reformer". The volume is devoted to sexual behavior and sex crimes.

Morphologic Hematology. Special Issue No. 1 of Blood, *The Journal of Hematology*. William Dameshek, M.D., Editor-in-Chief, (\$4.75. *Grune & Stratton, Inc., New York City*) presents some 28 individual contributions by distinguished authorities. This is the beginning of an attempt to revitalize the anatomy of blood cells in the hope that new and appropriate staining techniques will point directly to chemical and physiopathological alterations.

A Doctor in the House, by Henry Pleasants, Jr., M.D., (\$3.00. *J. B. Lippincott Company, Philadelphia*) deals in a lively fashion with the experiences of a physician.

Science in Farming. The Yearbook of Agriculture, 1943-1944, (*U. S. Department of Agriculture, U. S. Government Printing Office, Washington, D. C.*) tells the story of the more abundant life that is ours through modern methods of food production. To read this book is an education in today's science. It is one of a series of annals which has contributed much to your re-

porter, and it is more than a pleasure to welcome the yearbooks back. They were sadly missed during the war years.

Practical Psychiatry, by B. Liber, M.D., (\$3.50. *Melior Books, New York City*) presents for the layman as well as for the physician, the field that lies between mental health and mental disease. As such, it stands out for its emphasis on the "light mental cases", the transition cases between mental health and mental diseases. This is the beginning of prevention and hence this book deserves a wide reading—all the more since the author is an experienced teacher of health.

Handbook of Medical Emergencies, a group of thirteen Senior Harvard Medical Students (*Harvard University Press, Cambridge, Massachusetts*) devised this pocket manual to serve them when they went into their internships. This second edition has been done by five of the thirteen under the tutelage of some 23 physicians connected with the Harvard Medical School. It is a handy little manual full of helpful directions as just what to do.

Diet and Personality, by L. Jean Bogert, Ph.D., (\$2.00, *Garden City Publishing Company, Garden City, New York*) tells how one's temperament affects one's food habits and hence his state of nutrition. In spite of this, or because of it, your reporter believes that the state of nutrition of one's mother and one's self has much to do with the development of one's personality as it is formed through the function of the glands of internal secretion and the vegetative nervous system, both of which are dependent upon their nutrition. Anyway there is much that is sound and worth while about diet, nutrition, and normal living in this book.

Father of the Man, How Your Child Gets His Personality, by W. Allison Davis and Robert J. Havighurst, (\$2.75. *Houghton Mifflin, Boston, Massachusetts*) is based upon the study of 202 families. It carries out a study of the processes of human socialization begun in early childhood.

Nursing in Modern Society, by Mary Ella Chayer, R.N., (\$4.00. *G. P. Putnam's Sons, New York City*) is the first of a series which has been named "Modern Nursing", and constitutes an introduction to them since it presents an enveloping concept of the true place of nursing today in the social background of which it is a part.

Public Health Law, by James A. Tobey, (\$4.50. Third Edition. *The Commonwealth Fund, New York City*). Practically all who

enter the field almost immediately demand a law be passed hastening the millennium. The viewpoint of the author is that of the Earl of Derby, "sanitary instruction is more important than sanitary legislation". The author warns against the adoption of regulations unless it is intended that they be enforced. A large portion of the book is devoted to a consideration of the legal problems of disease control. In this third edition, we have the advantage of some 250 new decisions of the courts of last resort. The work will continue to serve the useful purpose of interpreting the law to the public health officers and the public health to the lawyer and judge.

Animal Nutrition, by Leonard A. Maynard, Ph. D., D. Sc., Director of the School of Nutrition at Cornell University, (\$5.00. Second Edition. *McGraw-Hill Book Company, Inc., New York City*) should be read by every physician for these livestock people have a lot more information than we medical men. It seems that we all know sickness in the barnyard is costly and animals can be kept in robust health through the use of good foods. But with us humans, well, we just do not think about health at all.

Blood Derivatives and Substitutes, by Charles Stanley White, M. D., and Jacob Joseph Weinstein, M. D., (\$7.50. *Williams & Wilkins, Baltimore, Maryland*) gives all the details about the preparation, storage, administration, and clinical results including a discussion of shock, its etiology, physiology, pathology, and management. As Major General Kirk says in the foreword, "Available information on this subject has been ably presented by the authors both from the knowledge gained in research as well as in the clinical use of plasma and whole blood."

On Hospitals, by S. S. Goldwater, M. D., (\$9.00. *Macmillan Company, New York City*) tells the story of the modern history and its development, its shortcomings, and the means of correction. In view of our present-day building program, it is fortunate that the writings of this great hospital administrator have been preserved and it would be most helpful to have them in one's own library.

Unipolar Lead Electrocardiography, by Emanuel Goldberger, M. D., (\$4.00. *Lea & Febiger, Philadelphia*) includes a discussion of standard leads, unipolar externity leads, and multiple unipolar precordial leads. This monograph of 182 pages explains the advantages of the unipolar leads.

Sir Frederick Banting, by Lloyd Stevenson, M. D., (\$6.00. *The Ryerson Press, Publishers, Toronto, Ontario, Canada*) is the story of a persistent soul who overcame many difficulties to perfect his discovery. It is another illustration of the fallacy

of governmental-controlled research and should be a lesson to our Congress now being misled by scientists who realize that the "new deal" years have dried up our sources of gift for research and teaching and so, to hold their job, they sell themselves to the politicians. Banting made his great discovery because his mind had become sensitized and through this "allergy" was prepared to act on the more or less accidental contact with the appropriate stimulus. Allergic minds cannot be bought or created with government funds.

Sexual Behavior in the Human Male, by Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin, (\$6.50. *W. B. Saunders Company, Philadelphia*) is the first book of its kind. Here is swept away the cobwebs of history. Our knowledge of the subject heretofore has been fragmentary—the confession of the abnormal, the fantasies (literally) of the fiction and scenario writers, and the experiences of a few physicians.

This book, however, is an objective factual study of the sexual behavior of the human male. It is based on scientifically devised interviews for over 12,500 persons. Every physician, everyone who is ever called upon to advise another about his sex life, should study this work.

If the technique stands up, as it certainly should, this should be applied to other phases of our behavior as human beings. The psychological conditioning of this thing we call education makes such a great difference in our outlook upon sex and its gratification that we ought to know what it is that it does to the other aspects of social behavior.

Fatigue and Impairment in Man, by S. Howard Bartley, Ph. D., and Eloise Chute, M. A., and the foreword by A. C. Ivy, Ph. D., M. D., (\$5.50. *McGraw-Hill Book Company, New York City*) organizes the scattered and contradictory ideas in the whole broad field. In these days of exterior industrialization we need to know all about fatigue and to distinguish it from impairment. This little volume drives the base line by integrating the findings from a great mass of literature.

Help Them Help Themselves, by Juliette McIntosh Gratke, (\$2.50. *Texas Society for Crippled Children, 3703 Worth Street, Dallas, Texas*) fills the need for an explanatory text of how to help the spastic.

Recent Advances in Endocrinology, by A. T. Cameron, (\$5.00. Sixth Edition. *Blakiston Company, Philadelphia*) presents many slight changes throughout the text in keeping with the many new changes that have occurred in practice since the last edition. Such things as artificial iodo-proteins with thyroid-like action, the use of

thiouracil in prolonged hypothyroidism, Dr. Hims-wroth's methods of the most successful and most prolonged treatment of Addison's Disease, and many other less important but interesting things have been included in this revision.

Science and Freedom, by Lyman Bryson, (\$2.75. *Columbia University Press, New York City*) is an essay of some 175 small pages by the well-known radio commentator discussing the use of the scientific method in understanding human behavior and the application of scientific knowledge to the management of human affairs.

Studies of Schistosomiasis, National Institute of Health Bulletin No. 189, (*Federal Security Agency, U.S.P.H.S., Washington, D. C.*) is an encyclopedic symposium on this interesting disease.

Overcoming Stammering, by Charles Pellman, (\$3.00. *The Beechhurst Press, New York City*) is a brief compendium of the excellent theories for the correction of stammering and just criticism of current methods of treatment.

Curare, Its History, Nature, and Clinical Use, by A. R. McIntyre, Ph. D., M. D., (\$5.00. *University of Chicago Press, Chicago, Illinois*) is a complete summary of this drug which is coming back into the spot light.

Biochemistry for Medical Students, by William Veale Thorpe, (\$5.00 Fourth Edition. *Williams & Wilkins Company, Baltimore, Maryland*) is brought up to date, even introducing a chapter on isotopes as well as new material on protein structure, co-enzymes, fluoro protein, and nutrition in wartime.

Hearing and Deafness, A Guide for Laymen, by Hallowell Davis, M. D., (\$5.00. *Murray Hill Books, Inc., New York City—a subsidiary of Rinehart & Company, Inc.*) will do much to change favorably the attitude of hearing people. Here is information—lots of it—correct, easy to read, covering nearly every phase of the problem.

Congenital Malformations of the Heart, by Helen B. Taussig, M. D., (\$10.00. *The Commonwealth Fund, New York City*) is by a woman whose major interest from her freshman year in medical school to date has been in the heart. This, however, is not only a descriptive text of the lesions encountered but, for a long time to come, it will be the reference work in their diagnosis.

Music and Medicine, edited by Dorothy M. Schullian and Max Schoen, (\$6.50. *Henry Schuman, Inc., New York City*) is a timely symposium. Recent years have witnessed an amazing growth in the interdependence of music and medicine. The growth was apparent in particu-

lar in the increased role played by musical therapy in military hospitals and in the increasingly frequent use of music in industrial plants. This volume attempts to throw some light upon the problem created by the recognition of this interdependence. I am happy to note that there is a chapter on the occupational diseases of musicians by the distinguished industrial physician of Detroit, Dr. Alfred H. Whittaker, president of the Medical Alumni of the Ohio State University.

As You Sow, by Walter Goldschmidt, (\$4.00. *Harcourt, Brace & Company, Inc., New York City*) describes how industrialized farming is changing the American way of life. We physicians have a real stake in this change. It means unionization of farm labor, its loss of a sense of security, and the development of dependence upon its leaders—the seizure of the plant in which they work by this group—i. e., the advent of socialism.

Great Men of Medicine, by Ruth Fox, (\$2.50. *Random House Inc., New York City*) gives the background of modern medicine by reciting the lives of Vesalius, Pare, Harvey, Jenner, Laenec, Semmelweis, Morton Lister, and Koch. The author is a successful writer—one of those ever increasing number who prepared for medical college but never entered.

Office Treatment of the Eye, by Elias Selinger, M. D., (\$7.75. *The Year Book Publishers, Chicago, Illinois*) describes the ordinary office procedures and routine ophthalmologic treatments in detail. A handy office manual.

Insects and Human Welfare, by Charles T. Brues, (\$2.50. Revised Edition. *Harvard University Press, Cambridge, Massachusetts*) is an account of the most important relations of insects to the health of man, to agriculture, and to forestry in the light of the war (1917-1947).

Modern Cosmeticology, by Ralph G. Harry, F.R.I.C., with foreword by P. B. Mumford, M. D., (\$12.00. *Chemical Publishing Co., Inc., Brooklyn, New York*) is a book that allergists and dermatologists should have in their libraries. Physicians are primarily interested in treatment of skin lesions whereas commercial scientists are interested primarily in the cosmetic reaction of the purchaser to the article provided. For them, "a concealed lesion may be preferable to a partially cured one". On the other hand, the successful physician learns to prescribe pleasantly in a vehicle which will transfer the therapeutic ingredient with efficiency to the injured tissues. The major problem is resolved so far as is presently possible. The author draws attention to the manner in which the lesions may be treated without grease, stain, irritation, or externally obvious drawbacks.

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The Differential Diagnosis and Treatment of the Diarrheas

Z. T. BERCOVITZ, M. D.

THE differential diagnosis and treatment of the diarrheas involves a thorough knowledge of the differences between those diarrheas which are associated with pathological lesions of the gastro-intestinal tract, such as duodenitis, jejunitis, ileitis, and colitis, and those which are caused by simple dysfunctions resulting from failure of hydrochloric acid or pancreatic secretion, and failure of absorption from the small bowel due to deficiency states or other factors. In addition, not infrequently in acute and chronic inflammatory conditions involving the small and large bowel there is present a strong psychogenic element which colors the entire picture. In fact, there are many patients in whom the diarrhea is of purely psychogenic origin. It therefore becomes necessary for the physician, when treating a patient suffering from diarrhea, to take into account all of these factors before prescribing the course of treatment.

THE DIFFERENTIAL DIAGNOSIS OF THE DIARRHEAS

The following diseases and conditions are included in the differential diagnosis of the diarrheas:

I. SPECIFIC INFECTIONS

Bacterial (*Shigella* group [bacillary dysentery], cholera, and other organisms whose role is not clearly understood, such as various streptococci and *Escherichia coli*)

Protozoan (*Endamoeba histolytica*, *Endolimax nana*, *Balantidium coli*, *Girardia lamblia*, and *Plasmodium falciparum*)

Presented at the Second General Session of the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947.

The Author

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Helminthic (*Schistosoma mansoni* and *S. japonicum*)

Virus Infections (*Lymphopathia venereum*)

II. NON-SPECIFIC

Chronic Ulcerative Colitis (cause unknown)

Diverticulitis

Illeitis (regional, terminal ileo-colitis)

Nutritional Deficiencies

III. OTHER CONDITIONS TO BE RULED OUT

Psychosomatic

Malignancy of the Gastro-intestinal Tract
Gastric, gallbladder, or pancreatic disease, and diseases of the genito-urinary tract

BACILLARY DYSENTERY

Bacillary dysentery is an acute inflammatory disease of the large bowel caused by one of the *Shigella* group of organisms. The intensity of the infection and the clinical picture vary within wide limits, depending upon the virulence of the infecting organism and the resistance of the patient at the time of the infection.

The usual clinical picture is characterized by

the sudden onset of diarrhea with straining, tenesmus, blood, mucus, and pus. The patient is toxic, feverish, and has bowel movements numbering 20, 30, or more a day. It can be stated that the patient is literally glued to the bedpan, and after great effort expels only a small amount of mucus and pus which stick to the bedpan.

On sigmoidoscopic examination, the bowel is found to be inflamed, necrotic, with definitely ragged ulcerations usually in the transverse axis of the bowel. Heavy, purulent, mucoid material is present, which on microscopic examination shows a heavy cellular exudate of polymorphonuclear leucocytes, denuded epithelial cells, and macrophage cells—all with ringed nuclei and with many toxic granules. It is possible to make a presumptive differential diagnosis between amebic and bacillary dysentery on the basis of cellular exudate studies. Cultural examinations made early in the disease directly from the ulceration will usually yield organisms of the *Shigella* group.

AMEBIC DYSENTERY

Amebic dysentery is caused by an infection with *Endamoeba histolytica*. In its simplest form, there is typical ulceration with a normal mucosa surrounding. The amebic colitis may be either acute or chronic. In the acute stages the symptom picture is quite characteristic, with diarrhea amounting to four, six or eight bowel movements in twenty-four hours, without straining or tenesmus. The patient is only moderately ill, and is not as toxic as in bacillary dysentery, generally, there is no fever. The bowel movements are usually copious and may or may not contain visible mucus and blood.

In those cases in which the infection has persisted for a considerable length of time and has become chronic, the clinical picture varies within very wide limits, and it is quite impossible to describe a so-called typical or classic picture of chronic amebiasis. There may be alternating diarrhea and constipation, some flatulence with more or less gas, and vague abdominal pains are frequently present which make the patient conscious of his abdomen. Constipation is not an infrequent symptom of amebiasis; in fact, there are a great many patients who claim that they have never had an attack of diarrhea, but have suffered only from constipation.

The diagnosis depends upon finding the typical forms of *E. histolytica* in specimens of stools or other bowel discharges. In making the diagnosis, the various concentration tests should be used, especially the Faust centrifugal floatation with zinc sulphate or Otto's modification of the technic. If these methods fail to reveal amebae, then the patient should be given saline enemas,

and freshly passed mucus examined for amebae. The patient also may be given a dose of Epsom salts, and the stools passed and examined in the laboratory while they are fresh and warm.

In evaluating the mucus specimens it should be remembered that there are many cells which come down in the bowel discharges and which may be confused with *E. histolytica*. These are most frequently macrophages, polymorphonuclear leucocytes, epithelial cells, and plasma cells, and cause confusion especially in freshly passed, unstained material. Cells of tissue origin should be carefully identified to avoid mistaking them for *E. histolytica*. Ofttimes chronic ulcerative colitis, carcinoma of the colon, especially the rectum or sigmoid, and lymphogranuloma are treated as chronic amebiasis and the real nature of the condition missed until it is too late to help the patient. To avoid such instances of mistaken diagnosis, the findings should be confirmed by those qualified in the differential diagnosis of amebiasis, especially by fixed stained preparations.

It should be pointed out that there are cases of chronic amebiasis of long duration in which it may not be possible to demonstrate forms of *E. histolytica* in the stools. This is particularly true of some of the complications of amebiasis, such as amebic granuloma, amebic hepatitis, and amebic typhilitis. In these instances the diagnosis must be made on the basis of clinical history, physical findings, and the response to specific therapy with emetine.

The complications of amebiasis have been outlined by Bercovitz,¹ and include secondary bacterial infection of the amebic ulcerations, perforation of the bowel, amebic hepatitis with or without abscess formation, amebic granuloma especially of the sigmoid or cecum amebic appendicitis, typhilitis, and the more uncommon complications of amebic abscess of the spleen following perforation of the splenic flexure of the colon, and amebic abscess of the brain and lungs. Amebic abscess of the prostate also has been seen.

CHRONIC ULCERATIVE COLITIS

The etiology of chronic ulcerative colitis is still obscure, despite the large number of studies made. An extensive analytical review of the literature on the etiology of chronic ulcerative colitis published by Ginsberg and Ivy² revealed that there is no single etiological factor responsible for all cases.

Chronic ulcerative colitis as a disease entity may follow many disease conditions. Amebic and bacillary dysentery have been followed by chronic ulcerative colitis; indeed, there are certain cases in which these infections might seem to be the precipitating agents. Undoubtedly emotional and psychogenic factors are involved,

but it is difficult to attribute sole cause to them. There have been many instances in which great emotional and psychological upsets have been attended by attacks of diarrhea with dysfunction of the bowel; and in such instances when the condition persists over a long period of time, it is conceivable that permanent bowel damage may occur.

Although the causative agent in chronic ulcerative colitis has not been established, it is essential to conduct prolonged and intensive investigation of all the possible factors and to give the patient the benefit of the various specific therapeutic measures available.

Complete investigation of cases of chronic ulcerative colitis involves repeated careful microscopic examination of exudates, both before and after saline enemas, for amebae, cellular exudate studies with Loeffler's methylene blue, sigmoidoscopy to rule out malignancy, cultures of mucus and bowel discharges for pathogenic microbes, and finally, roentgen-ray examination of the colon with the barium colon enema. In addition to these, it is essential to make gastric analyses and to determine plasma ascorbic acid, prothrombin clotting time, plasma proteins, and glucose tolerance. These studies will in many instances give the therapeutic indications for the patient as a whole.

ILEITIS

Ileitis may be acute or chronic, regional or generalized, and may be recurrent after resection of an infected portion of the bowel. A diagnosis of ileitis can readily be made, provided it is considered in the differential diagnosis. The final diagnosis of ileitis is made upon careful study of roentgen-ray films following ingestion of contrast media.

NON-SPECIFIC DIARRHEAS

Non-specific diarrheas are most frequently obscure as to origin and difficult to diagnose accurately. Diarrheas which follow acute or chronic recurrent infections such as amebic or bacillary dysentery generally fall into this grouping. In these cases, although the patient has diarrhea, it may not be possible to find the specific causative agent, for the patient usually has been given adequate therapy which destroyed the amebae or *Shigella* organisms. Other diarrheas included in the group of non-specific diarrheas are those which cannot be linked with specific infections, and consequently are hard to treat because of their unknown etiology.

In these patients the history of the character of the diarrhea is of the greatest importance, and oftentimes constitutes the only clue as to the type of diarrhea. As a rule, the diarrhea is quite profuse, copious, bulky, and with large amounts of gas. The evacuations are foul

smelling, the odor being entirely different from the ordinary. Its sickening sweetness is difficult to remove and causes considerable annoyance to the patient. Although there is fair control, movements are quite urgent, explosive, and foamy. There is no straining nor tenesmus, and the patient feels satisfied after an evacuation. In most instances the movements occur in the early morning hours or soon after the patient arises. There may be one or two such evacuations before breakfast, and still another two or three after breakfast. Thereafter the patient is quite comfortable for the balance of the day, with only an occasional movement after dinner.

Most noteworthy is the fact that there may not be much loss of weight, and the appetite is quite good. There is essentially no change visible by roentgen-ray films in the pattern of either the large or small bowel in most of these cases. As a rule, however, gastric fractional analysis will reveal a deficiency in hydrochloric acid. Laboratory methods may fail to show actual changes in pancreatic function, but an excess of fat will be found in the stools.

Emotional and psychic changes occur, especially in men who have served in the armed forces and had specific amebic or bacillary dysentery infections. The psychogenic factors in these cases are important and should not be discounted. It is imperative to remember that behind all of these there is dysfunction of secretion and absorption, and every effort should be made to correct the condition.

CARCINOMA

Diarrhea may be the earliest symptom of carcinoma of the large or small bowel. This is especially true of malignant conditions of the rectum and sigmoid areas. There may be no pain, a sudden onset simulating in many respects an acute episode of an acute infectious diarrhea with blood, mucus, or pus. On the other hand, any persistent diarrhea with blood or mucus should be carefully investigated for malignancy, especially if it occurs in older patients. Many of these patients attribute the diarrhea to some food they have eaten, and seem to be emphatic that they have never before had any bowel dysfunction.

The diagnosis of malignancies of the bowel, especially the rectum and sigmoid, frequently can be made by sigmoidoscopic examination. The patient should be properly prepared and relaxed to effect good examination. Tense and apprehensive patients should be given a sedative, and if necessary a rectal anesthetic such as nupercaine ointment prior to the examination. It is advisable to pass the sigmoidoscope under direct vision for the entire length of the instrument and to study the area at about 18 to

22 cm., with care taken to observe all of the mucosal surfaces. Roentgen-ray diagnosis of small malignancies of the rectum and sigmoid areas is not very satisfactory, but if malignancy is suspected, the roentgenologist should be informed of the possible diagnosis so that he will be sure to use special technics and methods.

DIVERTICULITIS

Diverticulitis is another cause of diarrhea which may be encountered. It is not to be confused with diverticulosis which occurs more frequently. Roentgen-ray films are the primary means of diagnosis of diverticulitis or diverticulosis. The differential diagnosis between these two conditions must be made on the basis of the clinical picture. In diverticulitis, there is pain, leucocytosis, and more or less diarrhea with or without blood and pus in the discharges depending upon the severity of the infection and its location. Treatment is usually conservative unless it is evident that perforation with peritonitis has occurred.

TREATMENT OF THE DIARRHEAS

Therapy of the diarrheas may be divided into two parts, namely, specific and general. Both forms of treatment should be carried on hand in hand. For the best results, the patient should be treated as a whole, as well as with drugs directed against the specific causative agent. The success of any program of therapy will depend upon the extent to which each of these is carried out.

In general, the patient and his problems must be carefully evaluated and every effort made to establish a definite anatomical diagnosis. It is unfair to both the physician and the patient to make the diagnosis of psychoneurosis without prolonged, painstaking investigation to arrive at the correct diagnosis. The patient with diarrhea cannot be treated casually or in a hurry. The physician must take time to understand his patient and win his confidence. It is only by carefully observing his patient, listening sympathetically, and encouraging him to release his worries and cares, that the physician can win his patient's confidence to be rewarded ultimately by being able to make a diagnosis. Often there are social aspects, intimate family and marital problems, financial difficulties, and even small worrisome matters, which are related to the problem, and it is a great comfort and benefit to the patient to know that the attending physician is concerned, understands, and is anxious to help.

The physician should under no condition tell the patient that he is psychoneurotic, but rather should reassure him that his complaints are quite justified. It should be remembered that any patient who has diarrhea, pain in the abdomen,

with loss of weight and strength over a period of time, is bound to become neurotic and distressed over matters which would ordinarily be taken in his stride. Furthermore, the physician should be aware that the psychoneurotic manifestations of bowel disease are frequently the first indication that there is anything wrong with the patient.

Every patient with diarrhea should be given proper treatment even though the symptoms appear to be purely psychosomatic in origin. This is especially so in patients with non-specific diarrheas. Such patients should be given special handling. Fears of complications, ulcerations, and cancers should be removed by the physician.

The general nutritional condition of the patient should be carefully evaluated with respect to fluid balance, proteins, and carbohydrates. Treatment should be given as described under the management of **Chronic Ulcerative Colitis**.

It is pointed out that almost every acute and chronic infection of the gastro-intestinal tract is associated with failure of hydrochloric acid secretion, as well as more or less failure of pancreatic secretion. Although a classic gastrogenic diarrhea cannot be demonstrated, nevertheless from a practical clinical standpoint, patients have been found to respond to therapy with large dosages of hydrochloric acid, pancreatic extracts, and liver extract injections. Such a program includes a high protein diet with a minimum of fats and carbohydrates; and one of the main reasons for failures noted with such a regime is the fact that sufficiently large dosages of hydrochloric acid and pancreatic extracts have not been given. It is recommended that 20 to 30 minims of dilute hydrochloric acid be given four times daily, together with at least 25 to 50 grains of pancreatic extract at each meal. The results with such treatment are not dramatic, but bowel function is restored to normal and the patient experiences a renewed sense of well-being.

It is cautioned that opiates are not only unnecessary but contraindicated since they are of little benefit to the diarrheal condition and may cause the patient to become addicted to the drug.

In general, patients with diarrhea should be treated as nutritional deficiency problems which if left uncorrected result in dysfunctions.

Specific infections such as amebic and bacillary dysentery should receive treatment aimed at the causative agent, as well as general systemic treatment outlined under **Chronic Ulcerative Colitis**, with full consideration of all of the factors described above.

TREATMENT OF AMEBIASIS

The therapeutic approach to the problem of amebiasis and its complications must include

TABLE I.—TREATMENT OF AMEBIC DYSENTERY*

Drug	Single Dose	Number of Doses Daily	Total Daily Dosage	Total Dosage of Single Course of Treatment	Indications
Emetine hydrochloride*	½ gr. (0.032 Gm.) Subcutaneously	2 (a.m. and p.m.)	1 gr. (0.065 Gm.)	7 gr. (0.455 Gm.)	Acute and chronic amebiasis, amebic, granuloma, hepatitis, typhilitis perforations
Diodoquin Tablets of 3.2 gr.	3 tablets	4 (three times a day after food and bedtime)	12 tablets (3.84 Gm.)	200 tablets (64.00 Gm.)	Acute and chronic amebiasis with trophozoites and cysts of <i>E. histolytica</i>
Chiniofon Tablets of 0.25 Gm. each	2-3 tablets	3 (three times a day after food)	6-9 tablets (1.5-2.25 Gm.)	100 tablets (2.50 Gm.)	Chronic amebiasis, cyst passers
Vioform Tablets of 0.25 Gm. each	3 tablets	3 (three times a day after food)	9 tablets (2.25 Gm.)	100 tablets (25.0 Gm.)	Acute and chronic amebiasis with cysts of <i>E. histolytica</i>
Carbarsone† Capsules of 0.25 Gm. each	1 capsule	2 (a.m. and p.m.)	2 capsules (0.5 Gm.)	20 capsules (5.0 Gm.)	Chronic amebiasis, with cysts

* Myocardial poison—give subcutaneously only. Never to be given by intravenous or intramuscular injection. Blood pressure and pulse should be checked before each injection. Patient should be kept at bed rest if possible.

† Carbarsone is an arsenical and should not be used in any cases suspected of liver damage, such as amebic hepatitis.

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a careful evaluation of the patient as a whole and treatment of the patient, and not only his parasites. It should be remembered that in more than 90 per cent of the cases of acute amebiasis studied there is some secondary bacterial infection of the bowel, and in about 50 per cent there is evidence of amebic hepatitis. Thus every patient should be carefully investigated for evidences of secondary infection, such as cellular exudates in the bowel discharges in amebiasis, liver tenderness, thickening of the bowel over the cecum or descending colon and sigmoid area.

Emetine is the most valuable drug in amebiasis, and is indicated in both the acute and chronic stages of infection, as well as in complications. Where the infection is of long duration the parasites tend to get deep into the tissues, and in such cases emetine is indicated. In cases of failure, it is not a question of the parasites being "emetine-fast", but rather a problem of secondary bacterial infection which makes it impossible for the drug to reach the parasites. The same applies to other drugs used in the treatment of amebiasis.

On the basis of the author's experience, the following course of therapy has been found most acceptable and results in complete eradication of the infection. A course of 7 grains of emetine is given simultaneously with a course of sulfadiazine in a dosage of 1 gram four times daily for seven days. This is then followed by a course of 200 tablets of diodoquin. Diodoquin is the drug of choice in that it causes the least amount of irritation with highest efficiency. The most important point to remember is that the dosage must be adequate. Therefore, a dosage of 200 tablets given in doses of 4 tablets four times daily (16 tablets for the total daily dosage) is used. The sulfadiazine may then be repeated once and followed again

by the diodoquin. Under this program there have been no failures.

Table I above is taken from a recent article by Bercovitz,¹ and summarizes the drugs most commonly used in therapy of amebiasis.

TREATMENT OF BACILLARY DYSENTERY

The therapeutic indications in bacillary dysentery, as in amebic dysentery, are twofold: (1) specific to eradicate the causative *Shigella* organism, and (2) general systemic to improve the general condition and comfort of the patient.

Specific therapy involves the use of one of the sulfonamide drugs. Sulfaguanidine has been shown to have a specific therapeutic action in bacillary dysentery; but sulfadiazine, used in various parts of the world where sulfaguanidine was not available, was found to have an equally specific action. In fact, in the author's experience in India, sulfadiazine became the drug of choice, and the response noted was as dramatic as that obtained with sulfaguanidine and equally as specific.

The recommended dosage of sulfaguanidine in the treatment of acute bacillary dysentery is 3 or 4 grams initially, followed by 2 grams every three hours day and night for the first twenty-four hours or until the bowel movements become less frequent, the straining and tenesmus are relieved, and there is a passage of fecal material. After the first twenty-four hours, the midnight dose may be omitted. It has been found that by the end of the second day the patient will have made sufficient progress to warrant reduction of the dose to 1 gram every four hours. This dosage should be continued for at least four or five days even though the patient appears to be symptom free.

The general systemic approach to the treatment of bacillary dysentery is equally as impor-

tant as the specific chemotherapy. The patient should be given by intravenous infusions 5 per cent glucose in normal saline. To each 1000 cc. may be added 100 mg. thiamine chloride, 100 mg. niacinamide, and 1000 mg. ascorbic acid. A minimum of 2000 cc. should be given intravenously until the patient is able to take adequate fluids by mouth. In addition, 500 cc. of plasma should be given intravenously during the first twenty-four hours, making a total of 2500 cc. of fluid injected the first day of treatment. Sedatives of the phenobarbital group may be administered, but the opiates, including paragoric, tincture of opium, are not only unnecessary but contraindicated. In most instances the patients appear more toxic and have more abdominal distress after the opiates. The response to sulfaguanidine or sulfadiazine is so prompt and effective that the opiates are unnecessary.

The diet should be high in proteins and vitamins, and the patient should be encouraged to eat solid foods and take fluids by mouth at the earliest possible moment. This is most important, since the patient with profuse diarrhea is losing proteins and vitamins which must be replenished. If it is remembered that the bowel movements are caused by the inflammation of the sigmoid and colon, and not by the food the patient eats, many patients will be saved from starvation, which often results because proteins and vitamins are not replaced as they are lost.

TREATMENT OF CHRONIC ULCERATIVE COLITIS

The treatment regime of chronic ulcerative colitis is the same as that underlying the handling of other inflammatory conditions of the bowel. It consists of two parts: (1) treatment of the patient as a whole, and (2) treatment directed against the specific infection of the bowel.

General Management: As previously stated, psychological and emotional factors must be considered in the management of chronic ulcerative colitis, much in the same way as in other forms of bowel dysfunction. The patient who has chronic diarrhea, abdominal pains, anorexia, nausea, and the general debility which goes with the disease, is also affected psychologically and becomes emotionally unstable.

Patients with chronic ulcerative colitis must be understood to be helped. It is imperative under no circumstances to make them feel that they are mental cases. They should be encouraged and repeatedly told that they will be cured and become normal again. Every sign of encouragement should be stressed, even if it is temporary, and the physician should never display his discouragement. The family physician must employ practical psychotherapy. The patient should be given time to talk and ask

questions, each of which should be answered carefully.

In addition to creating mental rest and peace of mind in his chronic ulcerative colitis patient, the physician should employ physical rest and relaxation. Narcotics and habit-forming drugs should be avoided. Opium has been a favorite drug to reduce bowel movements, but it is ineffective except as a temporary measure and has the disadvantage of becoming habit-forming. Many a patient with chronic ulcerative colitis has become an addict because of the unfortunate use of forms of opium. This practice should be eliminated. The barbiturates are much more satisfactory, but they, too, may be habit-forming. No matter what drug is used for sedation, it is important not to continue it for too long a period.

Nutrition and Diet: Maintenance of proper nutrition of the patient is the major problem confronting the physician treating a case of chronic ulcerative colitis. It must not be forgotten that the patient has a diarrhea and moves his bowels with blood, mucus, and pus because he has an inflammation of the bowel, especially of the recto-sigmoid area, and that he does not move his bowels because of the food taken into his mouth and swallowed, which may evoke a defecation reflex.

The physician should be prepared to dispel the erroneous belief of many patients that because they have diarrhea following any single meal it is to be attributed to the food consumed. This is important to ward off the ill effects of elimination of essential foods from the diet, when there is no just cause other than the patient feels it is the food he eats that causes the diarrhea.

The practice of giving perfectly bland diets to remove all roughage from the colon has not cured the inflammatory lesions of chronic ulcerative colitis. In fact, it has been noted that even when an ileostomy has been performed and the colon put entirely at rest in so far as fecal matter is concerned, the patient still passed blood, mucus, and pus from the rectum because of the inflammation present.

There is ample evidence to show that patients with chronic ulcerative colitis are soon depleted of their reserves of proteins, vitamins, and other essentials for nutrition and tissue repair. The therapeutic indications, therefore, are for an adequate, liberal diet with enough proteins, carbohydrates, and vitamins to replenish the losses suffered from the disease and the diarrhea. It should be remembered also that the patient with chronic ulcerative colitis does not absorb adequate amounts of food even though it is not possible to demonstrate roentgenologically any lesions of the small bowel. Thus the nutritive content of his diet must be increased to replace

his losses and to make up for the poor absorption of whatever food he does take in. It has been proved by experience that patients who take an adequate amount of food, not only feel better and are stronger, but they do not have as much abdominal distress.

The diet in chronic ulcerative colitis cases should include adequate amounts of proteins especially meats. These should be dictated by the taste and desires of the patient. Beef steaks, roast, chopped meats, boiled or broiled, and tastily served are excellent sources of essential proteins, and should form the basis of any chronic ulcerative colitis diet. Vegetables and fruits in keeping with the patient's likes and dislikes should also be served.

All food should be properly prepared and special attention should be given to serve the menu attractively, to stimulate the patient's appetite and desire for food. It has been a common experience that a patient will tolerate and eat many vegetables which are cooked and served in natural form, but will become nauseated at the sight of puréed spinach with butter, or other puréed and strained vegetables. Puréed vegetables may be disguised by using them in creamed soups, in which form they may be enjoyed; but it should be mentioned that the concept of serving puréed vegetables to prevent roughage and thus reduce bowel movements is without scientific foundation. On the contrary, experience has shown that the patient who eats an adequate amount of meats and vegetables does better and has less pain. The same applies to simple salads such as lettuce and well-ripened tomatoes, or fruit juices such as orange and grapefruit juice. The use of a whole orange or whole grapefruit is to be encouraged, and in many instances it has been found that the serving of grapefruit revived the appetite of the patient and stimulated his normal eating pattern.

The rule, then, in the nutritional management of chronic ulcerative colitis is the administration of high protein, high carbohydrate, high vitamin diets with intermediate feedings as often as possible, and every effort made to avoid starvation with further depletion of the body tissues.

Intravenous Fluids: Parenteral administration of body fluids, proteins, and vitamins is of indisputable value, and every patient should be given the benefit of such treatment. Intravenous infusions of 500 cc. of plasma once or even twice daily are indicated in severe cases. To each infusion may be added 100 mg. thiamine chloride, 100 mg. niacinamide, and 1000 mg. ascorbic acid. Blood transfusions in amounts of 250 to 500 cc. at frequent intervals are invaluable. In severe cases the use of blood and plasma daily or every other day may be ab-

solutely necessary to save life. It has been found that even chronic cases who are not moribund, but seem to be holding their own and maintaining a stationary course in their disease, may be helped considerably by parenteral administrations.

Intravenous infusions of glucose in normal saline are also indicated to maintain fluid balance in the patient. Vitamins in the same concentrations as in plasma infusions may be added to the glucose infusion. The total amount of fluid intake in cases of chronic ulcerative colitis should be a minimum of 2000 cc. daily.

The administration of parenteral injections should be determined by the physician after careful evaluation of the patient with respect to the number of bowel movements, the quantity of material passed, the nature of the evacuations, the diet, and the amount of food consumed by the patient. Ofttimes despite the fact that laboratory reports indicate seemingly adequate numbers of erythrocytes or plasma proteins, there may be need for supplementary parenteral administrations when these factors are considered.

Specific Chemotherapy: The use of specific drugs in chronic ulcerative colitis has been disappointing up until the present time. This was adequately brought out in the symposium on the use of the sulfonamides in gastro-intestinal diseases held by the American Gastroenterological Association and reported recently.³ Neither the sulfonamides, nor penicillin, nor streptomycin has been effective in bringing about cures. This has been the experience of all those who have followed their cases for sufficient time to make careful evaluation of their results.

The sulfonamides have been used extensively. It is true that in many instances there have been what seemed to be dramatic effects following the administration of the various forms of sulfonamides, but follow-up of these patients revealed no permanent "cures". However, the temporary beneficial effects noted would warrant the continued use of the sulfonamides provided the patient is carefully observed for untoward effects of these drugs and their use is not prolonged. It should be noted that merely changing the bacterial flora of the bowel contents is not sufficient to cure a case of chronic ulcerative colitis. The casual relationship of any single micro-organism to chronic ulcerative colitis has not been demonstrated adequately as yet.

Penicillin and streptomycin have given disappointing results. Some patients receiving streptomycin seem to become worse. In my experience penicillin has not even given the temporary beneficial effects sometimes seen following the administration of the sulfonamides.

Surgery: The surgical indications in chronic ulcerative colitis have been stated clearly by Cave^{4, 5} and others. The more frequent use of

ileostomy has been avoided because, up until the present time, it has been impossible to point to any considerable series of cases, in which it has been possible to reestablish the continuity of the bowel and return the patient to normal bowel status. In most instances permanent ileostomy with its associated inconvenience has been a stumbling block. Patients therefore have been carried on a medical regime in the vain hope of reaching a period of remission which will be prolonged and that a form of "cure" will be effected.

Such practice has in most instances resulted in the patient's becoming so weak and so depleted that when finally ileostomy was considered, the patient was in such poor condition that the surgical mortality of the operation is far out of proportion to what it should be from a purely technical standpoint. Furthermore, by the time ileostomy is considered, permanent damage to the bowel has taken place, and the pathological changes occurring may be irreversible so that the ileostomy becomes permanent with no chance for recovery of normal bowel function.

It is too early, at this time, and the number of cases is too small, to predict what the end results will be of experiments now in progress in which active therapy has been undertaken of the distal loop of the bowel following ileostomy. The results observed at this time are a marked improvement in the well-being of the patient, a decline in the sedimentation rate, and improvement in the objective appearance of the bowel wall. Further reports on progress will be forthcoming.

It may be that for the benefit of the patient, ileostomy will have to be performed earlier so that active therapy can be instituted and it may be possible to reestablish continuity of the bowel in the future after healing is complete. If, however, the delay is too long and the pathological changes have become irreversible, then no means of therapy will cause healing.

Prognosis and Complications: The prognosis of chronic ulcerative colitis should always be guarded because of the complications which generally occur. These have been outlined by Ricketts and Palmer.⁶ Under no circumstances is the true prognosis to be communicated to the patient or his immediate family. At all times the physician should hold out hope for eventual cure, and never display even the slightest doubt of the future lest the patient lose hope, quit fighting, and die. There are thousands of cases of chronic ulcerative colitis who have become useful citizens and are performing useful functions in society even though they do not represent "cures".

The attending physician should be alert to such complications as perforations of the bowel

wall. These may be minute, and as a rule are pin-point in character. They may result from the passage of infectious agents through the lymphatics to lodge in the bowel wall and cause a local area of peritoneal irritation with symptoms which point to a mild, more or less localized peritonitis.

The therapeutic indications in these cases is absolute rest in bed, the administration of one of the sulfonamides, preferably sulfadiazine, fluids by vein, and in cases where it is comforting, an ice bag.

In some instances the perforations may become larger, and actual abscesses may form along the bowel wall. These may become localized and well walled off, and under these conditions, it is better to treat the patient conservatively. If the bowel wall is so fragile that it has perforated spontaneously, the handling involved in finding the abscess and other manipulations may cause the death of the patient. Under these circumstances, there is no single surgical procedure which will cure the patient, and as a rule other perforations are likely to occur. If an abscess becomes definitely localized and seems to be near to the abdominal wall, simple drainage may be considered, but even this is of great danger to the patient.

Stricture of the bowel is another complication which commonly follows a prolonged case of chronic ulcerative colitis. This may be single in the rectum or there may be multiple strictures in various parts of the bowel. When it is known that a patient has developed one or more strictures of the bowel, great caution must be observed to maintain the feces in a liquid state. If the patient is allowed to have a solid fecal mass, obstruction of the bowel will develop, which is most difficult to relieve.

It is possible to maintain a patient in good nutritional state for a period of years with two or three mushy bowel movements daily. This may be accomplished by means of carefully regulated dosages of milk of magnesia or sodium sulfate. Castor oil is contraindicated because of its constipating effect. One patient was thus maintained for eight years.

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Reversible Heart Disease

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THE term "heart disease" still carries with it the connotation of a severe, progressive, and often fatal illness to many people. This concept persists despite the remarkable strides made in diagnosis and treatment. Prior to Herrick's work in 1912, occlusion of a major coronary artery was considered to be incompatible with life. Blumgart and Schlesinger,² however, concluded that all patients suffering primarily from angina pectoris would show old complete occlusion of at least one major coronary artery at autopsy. White³ and others have demonstrated that the average life expectancy of patients with angina pectoris was between eight and ten years, based on a long-term follow-up of 497 cases. Not infrequently an autopsy will disclose evidence of severe heart disease hitherto unsuspected and untreated. One must, therefore, assume that even without suitable treatment the prognosis in angina pectoris is not as gloomy as has been believed. By intelligent management, patients with coronary artery disease may be rehabilitated often to a surprising degree. It can therefore be concluded that coronary artery disease may be classed as a reversible condition. With more widespread use of the electrocardiogram many instances of coronary artery occlusion followed by apparently complete recovery are being seen.

The surgeons too have contributed their efforts in the attempt to alleviate coronary heart disease through the development of a collateral circulation to support the diseased and inadequate coronary arterial tree. The pectoral muscle and the omentum have been engrafted on the myocardium with this end in view.⁴ A more recent surgical approach is through the use of abrasive substances applied to the surface of the heart.⁵

Outstanding contributions have been made in the field of thyrocardiac disease. As a result of wider recognition of thyrotoxicosis and better adjunct therapy, one sees fewer cases of heart disease of this type today. White⁶ states that at one time 3 per cent of all cardiacs were of the thyrotoxic type. In the past twenty years, realistic and bold surgical therapy has rehabilitated many thyrocardiacs through the medium of sub-total thyroidectomy. Because of the amazing results obtained by appropriate treatment, internists are ever on the alert for the cardiac patient whose disability is due to

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toxic thyroid disease. Myxedema heart disease is now widely recognized and has become an example of reversible heart disease par excellence as a result of the remediable effects of thyroid gland administration.

Beriberi heart disease is another condition in which phenomenal results are obtained. Within a short period of time, the picture of cardiac enlargement and congestive failure completely subsides in the uncomplicated case with the use of thiamin chloride alone. It has only been in the last few years that the reversibility of beriberi heart disease has been recognized. The electrocardiographic abnormalities also revert to normal within a short period of time. Today the miracle of transformation of the failing deficiency heart into a normal heart is being duplicated in all parts of the country. The physician who is alert to the possibility is almost always rewarded by finding such a case sooner or later.

The acute dilatation of the heart which occurs in massive pulmonary embolism was called acute cor pulmonale by McGinn and White.⁷ Frequently, spontaneous reversal takes place and the patient recovers without any significant cardiac residuals. In some of these cases, classical electrocardiographic changes develop concomitantly with the acute episode and revert to normal within a short period of time if the patient survives. In this field, advances of significant degree have taken place as a result of stress upon the prevention of its occurrence through the use of postoperative exercises, anticoagulants, vein interruption in the lower extremities,

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and more recently ligation of the inferior vena cava.

The cure of the cardiac complications of arteriovenous aneurysm by surgical excision of this pathological vascular shunt is no longer a reportable curiosity.

Surgery has been responsible for the rather recent upsurge of interest in the alleviation of hypertensive disease. Through the Smithwick operation⁸ (dorsolumbar sympathectomy) a more significant and prolonged lowering of blood pressure has been accomplished than had hitherto resulted from any other therapeutic approach. Significant follow-ups are appearing in the literature reporting the beneficial results of this operation on the heart. Reduction in heart size and reversal of abnormal electrocardiographic changes have been effected. Thus far the use of renal extracts in the attempt to treat the hypertension has not been successful, nor have other medical approaches to the problem resulted in any significant degree of improvement.

Monumental progress has been made in the field of congenital heart disease. The advances in this important and hitherto hopeless realm were touched off by the work of Gross,⁹ when he successfully ligated a patent ductus arteriosus. Since then many operations of this type have been performed successfully. Following upon the heels of this work, other congenital cardiac conditions have been attacked through surgical means, thus broadening the indication for surgery. Crafoord and Nylin¹⁰ reported two cases of coarctation of the aorta cured by surgical means. Blalock and Taussig¹¹ have been able to effect remarkable improvement in cases of congenital heart disease in which there is pulmonary stenosis. Thus, an example of each of the three major types of congenital heart disease has become amenable to surgical therapy.

In discussing the achievement of surgery in reversing the effects of heart disease one must mention the brilliant results achieved by pericardiectomy in cases of constrictive pericarditis. This work was first stimulated in this country by Churchill in Boston.¹² Other surgeons have followed his lead and an impressive literature has been developed. As a result, the recognition of this condition and its differentiation from common types of cases of congestive failure is now being accomplished by internists the country over. The operation when successfully carried out produces a complete reversal of signs and symptoms. Hopeless invalids are sometimes rehabilitated in spectacular fashion.

Finally, the spectacular achievement of penicillin therapy in the cure of subacute bacterial endocarditis deserves mention. Reports have been made from all over the country of cures, which have not hitherto been possible. As a result of investigations in many clinics, schedules

of treatment are being developed which have resulted in a significant increase in the number of cures. The tendency is toward higher dosage of penicillin given over a longer period of time than was originally used in the treatment of this condition.

It is not our purpose to outline all the cardiac conditions to which the term reversible may be applied. This has been done in a masterful manner by White⁶ and Stewart.¹³ We desire only to list those in which the more spectacular results have been accomplished either by medical or surgical approaches. We have collected a few cases which exemplify the reversibility of heart disease and which have come to our attention within recent months. Examples of reversible heart disease are everywhere to be found. How sharply this contrasts with the hopeless attitude toward heart disease that prevailed until so recently.

CASE REPORTS

Case I. N. S. was a 47-year old white male admitted August 9, 1945, for the treatment of cirrhosis of the liver. He had been complaining for the past five years of epigastric distress following meals, sour eructations, and flatulence. For many years he had been a moderately severe alcoholic. For two weeks prior to this admission he noticed marked swelling of his scrotum, shortness of breath, hard pitting edema of the lower extremities, including the thighs, and swelling of the abdomen. The shortness of breath became so marked and disturbing that it was necessary for him to sit up in bed at night.

Examination revealed a cyanotic dyspneic, and orthopneic white male with edema involving the legs, thighs, scrotum, abdominal wall and chest wall. Acne rosacea was noted on the cheeks and across the bridge of the nose. The lung bases were dull to percussion and numerous moist coarse rales were heard throughout both lung fields. Blood pressure 130/90; pulse 110 with regular rhythm; respirations 24. The abdomen was dome shaped and revealed shifting dullness and a fluid wave. The liver was tender and palpated to 5 cm. below the right costal margin. The spleen was not palpated. The knee and ankle jerks were diminished, as was also the vibratory sense in both lower extremities.

Laboratory Data: Total protein 7.64; A/G ratio 1.45 to 1. Urine specific gravity 1.025; trace of albumin; 8 white blood cells per high powered field; no red blood cells; many hyaline and a few granular casts. Blood N. P. N. 40.5; icterus index 9; cephalin flocculation 3 plus. Normal blood count.

Course in the Hospital: The immediate condition which seemed to require attention was heart failure. Oral digitalization, restriction of salt and fluid intake; ammonium chloride and bed rest failed to influence the picture significantly. On August 9, 1945, thiamin chloride by parenteral administration was begun in 100 mgm. dosage. This was repeated daily. Diuresis promptly occurred and the patient's improvement began. Concomitantly he was placed on high vitamin intake, high carbohydrate, high protein and low fat diet, and elixir choline chloride; amino acids were administered by

oral route. A marked improvement in well-being occurred. All the edema subsided, the neurological abnormalities disappeared; the liver decreased in size somewhat and lost its tenderness. It was concluded that this was a case of beriberi heart disease complicated by cirrhosis of the liver.

Comment: This case represents a typical picture of beriberi heart disease with associated cirrhosis of the liver. The response to thiamine

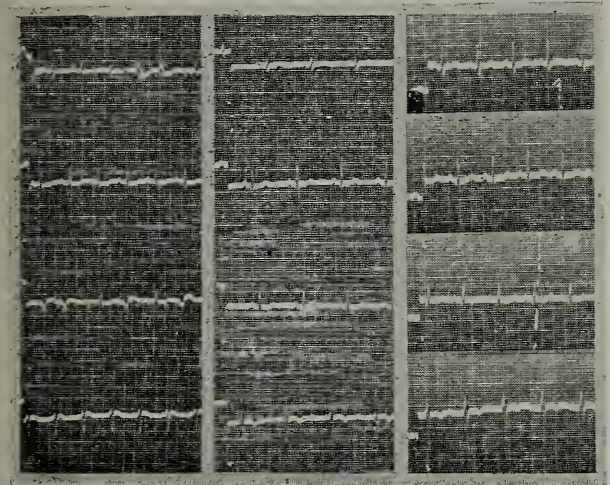


Figure 1—Tracing taken August 17, 1945, reveals many premature ventricular constructions, low QRS and T waves. Figure 2—Tracing taken September 1, 1945, reveals an increase in the amplitude of QRS and T waves. T waves in lead CF4 are inverted. Figure 3—Tracing taken September 25, 1945. The standard leads are fairly normal, T waves in lead CF4 are inverted.

chloride was dramatic and confirmed the clinical impression. By the use of this therapeutic test this diagnosis may be confirmed. The electrocardiograms show the striking reversibility of the abnormality of the complexes. See Figures 1, 2, and 3.

* * *

Case II: W. W. R. was a 23-year old white male admitted October 2, 1945, for treatment of hypertension and tachycardia. The family and childhood history was irrelevant. He entered the Army on January 14, 1943. In August, 1944, while on field maneuvers in North Carolina, he developed an attack of palpitation which lasted one month, from which spontaneous recovery took place. Following this, he was discharged from the service. Without any known aggravating factor, he developed palpitation and pain in the right upper abdomen on September 30. This attack persisted and on October 2, 1944, he was admitted to this Center. On admission the veteran was in obvious congestive heart failure. He complained of shortness of breath, cough, and a fluttering sensation around the heart. The blood pressure was 100/80. The pulse was 180. There was slight cyanosis of the lips and nail beds, dyspnea and slightly distended neck veins. There was tender enlargement of the liver 8 cm. below the right costal margin. There was no edema of the feet. An X-ray of the chest showed generalized enlargement of the heart with evidence of severe pulmonary congestion. The electrocardiogram showed supraventricular paroxysmal tachycardia probably nodal in type. The various mechanical maneuvers for vagal stimulation were attempted but proved unsuccessful. He failed to respond to prostigmin, quinidine, and an injection of acetylcholine chloride. On October 4, oral

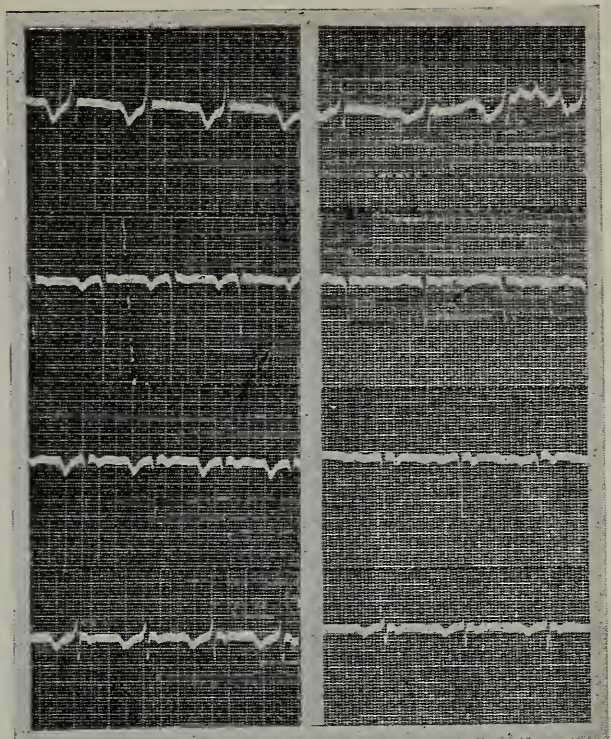


Figure 4—Tracing taken October 2, 1944, shows supraventricular tachycardia, rate is 195. Figure 5—Tracing taken October 6, 1944, upon subsidence of the paroxysm of tachycardia, shows bizarre T waves with prolonged QT intervals (.48 sec) probably due to myocardial ischemia, the result of the prolonged tachycardia.

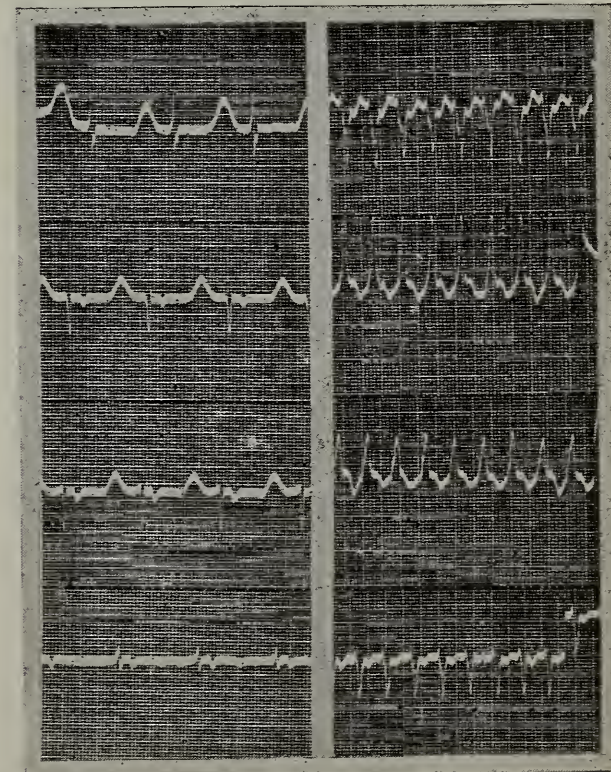


Figure 6—Tracing taken October 23, 1944, still shows low T waves Figure 7—Tracing taken February 6, 1946, is within normal limits. QT interval is now .36 sec.

digitalization was begun. After receiving fifteen grains of digitalis, the paroxysm of tachycardia ceased on October 6. Signs of heart failure rapidly subsided and the veteran was kept on maintenance dosage of digitalis until his discharge on October 30, 1944. In February, 1945, another attack of paroxysmal tachycardia was suffered which lasted five days and again in December, 1945, a ten-day attack occurred. Both

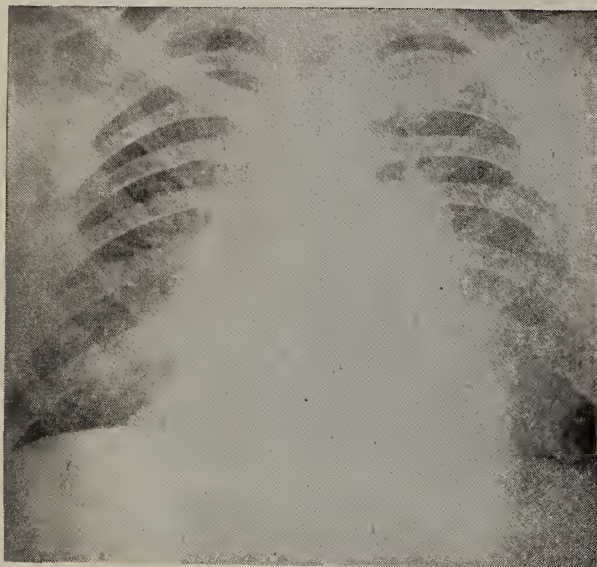


Figure 8. Case II—Teleoroentgenogram of chest taken October 3, 1944, shows cardiac enlargement to right and left. Transverse cardiac diameter is 17 cm. A severe degree of pulmonary congestion is noted.

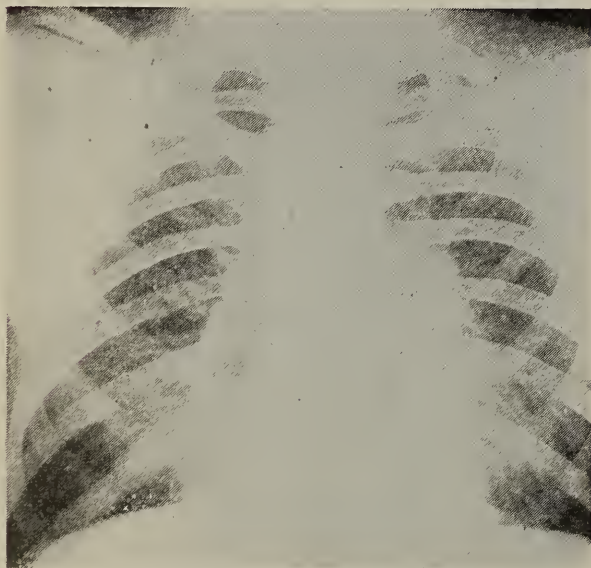


Figure 9. Case II—Teleoroentgenogram taken February 27, 1946, shows a normal cardiac silhouette.

of these attacks were treated by private physicians. He was again seen at the center in February, 1946, when he was admitted because of chronic epididymo-orchitis of undetermined cause. At this time no cardiac abnormalities were detected. See Figures 4 to 7 for EKG changes noted. Figures 8 and 9 show the appearance of the chest roentgenograms in 1944 and 1946.

Comment: This case is of considerable interest in that it represents a somewhat uncommon oc-

currence. Cardiac failure resulting from prolonged tachycardia in an otherwise normal heart is mentioned in all standard textbooks, but is not ordinarily seen in clinical experience. Again the electrocardiographic abnormalities following the recovery from the paroxysm of tachycardia are truly unusual. Ward¹⁴ reported a case which is remarkably similar to the one described above. This author warns against the rash interpretation of these electrocardiographic abnormalities as being due to organic disease such as coronary thrombosis. That such an error may be made by the inexperienced is obvious. The complete reversibility of both the heart size and striking electrocardiographic abnormalities is illustrated.

* * *

Case III: H. H., white, farmer, aged 50, was admitted to the hospital March 17, 1946. He was a known case of pernicious anemia of six years' duration. For the past several months he had taken no liver injections, relying on capsules of lextron. He soon developed weakness, numbness and tingling of the legs, tired easily, and became very pale. He also developed difficulty in walking and dizziness. His legs began to swell and he became breathless on slight exertion. He was pale and appeared chronically ill on admission. The skin was lemon yellow, the mucus membranes were pale, the tongue was smooth. Blood pressure was 120/68, pulse 100. The apex impulse was located at the left midclavicular line. The rhythm was regular and the heart tones were of good quality. A blowing systolic murmur was heard at the apex which was not transmitted. The liver and spleen were not enlarged and there was no ascites. Four plus pitting edema extended up the legs to the knees. Loss of position sense and vibratory perception of both legs were noted. Blood count March 18, 1946, revealed red blood cells 2,230,000; hemoglobin 44 per cent; white blood cells 6,400 with 62 per cent polymorphonuclears, 37 per cent, lymphocytes, and 1 per cent monocytes. There was marked anisocytosis, mostly macrocytes. The electrocardiogram was within normal limits. Teleoroentgenogram on March 18 showed cardiac enlargement. Transverse cardiac diameter 15.5 cm. A recheck film one month later showed return of the heart size to normal. The usual treatment, utilizing liver extract and vitamin B complex resulted in marked improvement with loss of edema, sense of fatigue and pallor. The neurological sign improved but did not entirely disappear at the time of discharge.

Comment: This case illustrates a rather common occurrence which can be frequently seen if careful cardiac studies are made. It occurs not only in pernicious anemia, but in the anemias secondary to other factors, such as acute or chronic blood loss. If the physician is unaware of the frequency of cardiac enlargement with its accompanying abnormal sounds and electrocardiographic variations, the diagnosis of a grave cardiac disorder will often be made.

* * *

Case IV: W. G., a 52-year old white male, was admitted to the hospital because of multiple lacerations of the scalp received when he was blackjacked by thugs. After admission a septic fever appeared, associated with swelling, pain, tenderness, and limitations of motion of the right wrist. In rapid succession the right knee, left knee, left wrist, and left ankle became involved. A similar attack of migratory joint pain had occurred one year previously. The

patient was well developed and well nourished. His height was 5' 7½". He weighed 192 pounds. He appeared acutely ill. The blood pressure was 144/78, pulse 100, temperature 102. The point of maximum impulse was in the sixth interspace



Figure 10, Case IV—Teleoroentgenogram taken February 13, 1946, showing water bottle contour of heart due to pericardial effusion.

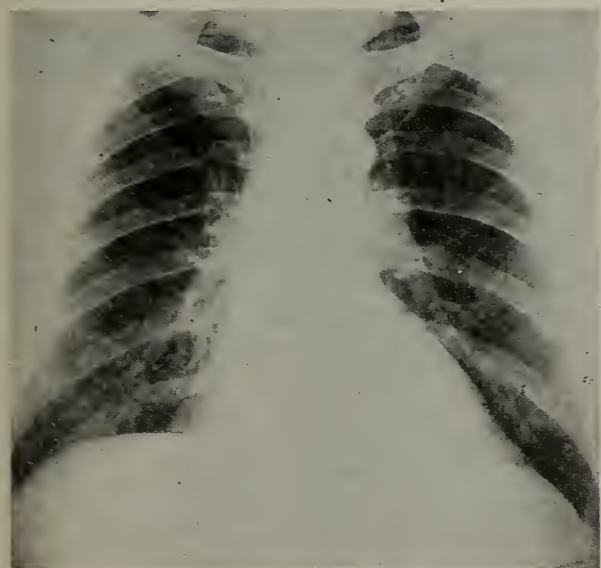


Figure 11, Case IV—Teleoroentgenogram taken April 15, 1946, showing return of cardiac shadow to normal.

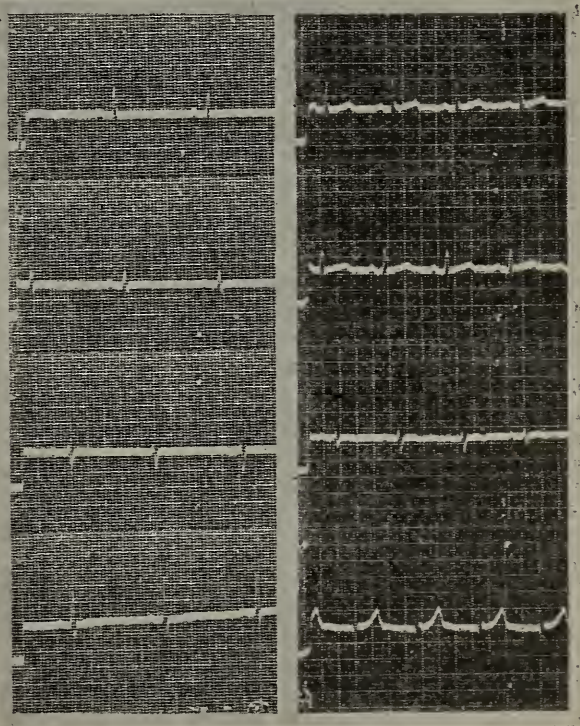
at the anterior axillary line. On percussion, the heart appeared enlarged both to the right and to the left. The heart sounds were distant, no murmurs were heard, no thrills were felt, no friction rub was audible. The neck veins were distended and there was no peripheral edema. The liver was slightly enlarged and was somewhat tender. There was no ascites. He was slightly cyanotic, and it was necessary for him to sit in an upright position to breathe comfortably. Moist rales were noted at the lung bases posteriorly. Aside from the swollen joints and lacerations of the scalp, the remainder of the physical examination was negative. The sedimentation rate was 31 mm. per hour. The urinalysis Kahn, Kline, and Wassermann tests were

negative. On admission, the blood count showed red blood cells 3,970,000, hemoglobin 81 per cent white blood cells 22,450 with 85 per cent polymorphonuclears. Agglutination tests for typhoid, paratyphoid, and brucellosis were negative. The N. P. N. creatinine, and blood sugar determinations were normal. Blood cultures were negative. An X-ray of the heart and lungs on February 13, 1946, showed enlargement of the cardiac silhouette of water bottle type. See Figure 10. An electrocardiogram showed left axis deviation with flattening of the T waves. The patient did not benefit from adequate doses of penicillin or sulfadiazine. On salicylate therapy and pericardial paracentesis, improvement was immediate, dramatic, and gratifying. The cardiac shadow returned to normal size. See Figure 11. The patient was discharged, apparently fully recovered.

Comment: This case illustrates the striking variations in heart size which are seen in rheumatic heart disease. Commonly, patients with rheumatic fever develop evidence of heart failure with or without pericardial effusion. Although desperately ill with well-marked objective signs of cardiac decompensation and at times cardiac tamponade, they often recover in surprising degree with resulting few or no evidences of the severe cardiac pathology seen earlier in their clinical course. Figures 10 and 11 clearly show the marked differences in cardiac size before and after treatment.

* * *

Case V: A. W., age 56, was a laborer. He has had many admissions to the hospital. He was of low mentality and a chronic alcoholic. The diagnosis of hypothyroidism has been well



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13

Figure 12—Tracing taken September 8, 1943, before thyroid therapy. Note flat T waves.
Figure 13—Tracing taken October 4, 1943, after thyroid therapy. Note the increased amplitude of T waves.

established by adequate clinical and laboratory investigation over the past six years. His many admissions have been precipitated by his failure to take the thyroid medication recommended for

him. On admission he presented the usual picture of myxedema. The heart was somewhat enlarged as shown by teleroentgenogram. After treatment, it returned to normal size. The electrocardiogram on admission, Figure 12, showed flat to inverted T waves in all leads. After thyroid therapy, Figure 13, the T waves became upright and the tracing was within normal limits.

Comment: In cases of myxedema heart disease, the electrocardiogram shows low complexes before treatment and unless there is significant accompanying coronary artery disease with myocardial damage, the tracing assumes a normal appearance following adequate thyroid extract administration.

SUMMARY

1. Five examples of reversible cardiac conditions are described. Of these, one is a somewhat unusual case of congestive heart failure superimposed on prolonged paroxysmal tachycardia. This latter case also illustrates the infrequent finding of bizarre T waves seen after an attack of paroxysmal tachycardia.

2. A grave prognosis given with reference to cardiac patients should be carefully weighed in the light of the frequently demonstrated reversibility of heart disease.

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Error in December Issue

In the December issue, through an oversight on the part of the Editor, the word "Dilantin" was used as a generic name.

We had no intention of contributing to the loss of the property rights of Parke, Davis and Company in this name through its misuse in our pages.

KEEPING UP WITH MEDICINE

• ONE half of the diabetics in the United States are sixty years of age or older.

* * *

• THE man frequently is the cause in a barren marriage (10 per cent of the marriages in this country are not fertile) and his evaluation is simple although fertility in both partners is essential.

* * *

• ACCORDING to the current conception, periarteritis nodosa is the result of an anaphylactoid antigen-antibody reaction in which the arteries are the "shock organs".

* * *

• THE use of gold salts in rheumatoid arthritis may cause hepatic cell damage directly to the liver cells, indirectly by hemolysis or by means of allergy.

* * *

• THE value of immunization with inactivated influenza virus vaccine has been well established.

* * *

• IN the management of eczema in children, the best results are obtained if the case is viewed from the standpoint of diet, environment, psychosomatic, and constitutional phases in conjunction with the treatment of the local lesion.

* * *

• HIATUS hernia may well be mistaken for a case of coronary thrombosis.

* * *

• DIRECTLY or indirectly those patients with seborrhea, ichthyosis, and hyperhidrosis are vulnerable to contact dermatitis and this should be taken into account in pre-employment examination.

* * *

• FUNGUS infection of the feet is really a symbiosis between fungi and bacteria. Strong disinfectants should not be used for fear of a dermatitis.

* * *

• CHRONIC dermatitis, particularly when accompanied with pruritus, may result in a characteristic type of hyperplasia of the lymph nodes.

* * *

• RECENT statistical studies show that the incidence of all venereal disease is significantly higher among uncircumcised males than among those who have been circumcised.

* * *

• TO finance research for the study of diabetes, there should be a "March of Four-Bit Pieces" since it is five times more frequent than "polio".—J. F.

Chemotherapy in Infants and Children

III. Streptomycin

J. G. KRAMER, M. D.

AMONG several antibiotic substances extracted from *Actinomyces* by Waksman and his colleagues, one known as streptomycin has proven to be very important since it is very antagonistic to many organisms not inhibited either by penicillin or the sulfonamides. It does take care of some gram positive organisms, but not as well as penicillin, therefore it is used on these organisms only when they are penicillin fast. Streptomycin is very active in vitro against a wide variety of gram negative organisms; there are however certain failures of the vivo activity.¹ Chart III is of clinical interest with its list of organisms susceptible to streptomycin.

CHART III

B. Tularensis	A. Aerogenes
H. Influenza	B. Pyocyaneus
E. Coli	B. Para-typhoid
B. Proteus	Streptococcus Faecalis
B. Vulgaris	Tubercle Bacillus
K. Pneumoniae	

ADMINISTRATION

Streptomycin can be administered intravenously, intramuscularly, subcutaneously, intrathecally, orally, or by nebulization. The intravenous route is not the one of choice for infants and children. Intramuscular and subcutaneous injections of 100,000 units in adults resulted in adequate blood levels over a period of three hours. When repeated doses were given at three-hour intervals either intramuscularly or subcutaneously, high blood levels were built up, the highest resulting from the subcutaneous route. The dosage of streptomycin should be large from the beginning and should be administered every three hours day and night, around the clock. Large repeated doses are necessary because many of the supposed susceptible organisms are really very resistant to the drug and many organisms rapidly develop resistance during the course of treatment.

Dosage of the drug can be expressed in both units and grams. One gram is equal to 1,000,000 units. Dilutions are made either in distilled water or normal saline in concentrations of 100,000 units per cc. Both drug and diluent must be kept cold at all times. Dosage will vary according to age and severity of the infection. For infants and young children the average dose

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should be between 75,000 units or 75 mgm. to 125,000 units or 125 mgm. For older children 100,000 units or 100 mgm. to 200,000 units or 200 mgm. administered every three hours. Procaine may be added to the solution to relieve the pain at the site of the injection.

INTRATHECAL ADMINISTRATION

Since little streptomycin passes into the spinal fluid after systemic administration either in normal or diseased condition of the meninges, the drug should be administered intrathecally. Fifty to 100,000 units diluted in normal saline, 10,000 per each cc. may be injected intrathecally. Less fluid should be injected than was removed. This need be repeated only every twenty-four hours since adequate bacteriostatic concentration remain for that period of time.

Since streptomycin has an almost specific action on the influenza bacillus its most important function in pediatrics at present is in the treatment of influenza meningitis. Here the action is most efficient and reported results have been good. One should not however rely on streptomycin alone but also use influenza rabbit serum as well as sulfadiazine—all in optimal dosage.

AEROSOL TREATMENT

Streptomycin can also be nebulized the same as penicillin and inhaled for the treatment of respiratory infections caused by gram negative organisms.² It can be combined with penicillin for use in mixed infections or can follow penicillin aerosol treatment where the gram positive flora have been eradicated with penicillin leaving a residue of gram negative, penicillin resistant organisms.² Twenty-five thousand to 50,000 units of streptomycin per cc. of physiologic saline solution can be nebulized each hour or two throughout the day without untoward reactions.

Since gastric juice does not destroy streptomycin it may be administered by mouth. However, little or no streptomycin is absorbed

¹ Presented before the Section on Pediatrics at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947. Parts I and II published in the February and March issues respectively.

from the intestinal tract.^{1,3} When administered orally it promptly suppresses or eliminates drug sensitive strains of colon bacilli, typhoid bacilli,⁴ para-typhoid bacilli, dysentery bacilli, as well as other intestinal bacteria so long as treatment is maintained. Cessation of treatment is followed by a rapid return of the flora. This temporary respite from the infection may prove to be very beneficial especially to newborns and infants with intestinal infections. During the respite, the nutrition and well being of the infant can be improved and this should aid the resistance and defenses against infection. In the dysentery group infections the combined use of streptomycin and sulfaguanidine might offer more permanent results. For oral dosage of streptomycin 50,000 to 100,000 units may be given every four hours.

URINARY INFECTIONS

Since two thirds of the amounts of streptomycin given parenterally are recovered from the urine^{1,4} the high concentrations resulting therefrom make it an ideal drug for urinary infections.¹ Helmholtz⁵ believes it should prove the most useful urinary antiseptic so far developed for sensitive organisms. The usual standard dosage should suffice. In infants and children urinary tract obstruction is the commonest cause of chronic urinary infection. While streptomycin will sterilize the urine, a reinfection will follow shortly unless obstruction is relieved by mechanical means.

Streptomycin can be injected into the pleural, pericardial and joint cavities when they are infected with sensitive organisms. Since streptomycin is secreted into the peritoneal cavity in levels higher than the blood, local injections are usually not necessary in peritoneal infections.¹

Tularemia responds to treatment with streptomycin, the dosage should be regulated by the severity of the disease.

The bacillus of tuberculosis is susceptible in vitro to the action of streptomycin.⁶ Attempts to apply this clinically have not as yet produced conclusive results. The treatment of cutaneous tuberculosis and urinary tract tuberculosis has responded much better than pulmonary and meningeal involvement. The best that can be said is that the tubercle bacillus has been temporarily inhibited by the streptomycin. In other words there resulted a limited suppressive effect. Until more conclusive evidence of efficacy is obtained for streptomycin, other therapeutic means should not be abandoned.

TOXICITY

Streptomycin is a drug of low toxicity, however certain immediate toxic effects may appear such as fever, headache, flushing, erythema, urticaria, and tachycardia.¹ After streptomycin

has been administered for three weeks or more an involvement of the eighth nerve may become apparent. This manifests itself by the appearance of vertiga tinnitus and deafness. This eighth nerve complication responds to the withdrawal of the drug in all but a small percentage in about three months' time.

Streptomycin should be looked upon as a drug for a specific purpose. It should not be con-

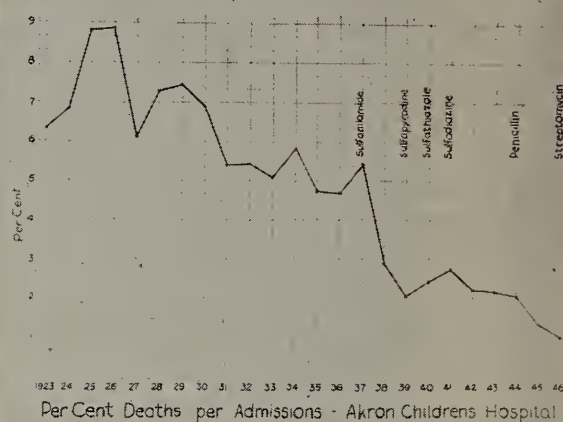


CHART IV

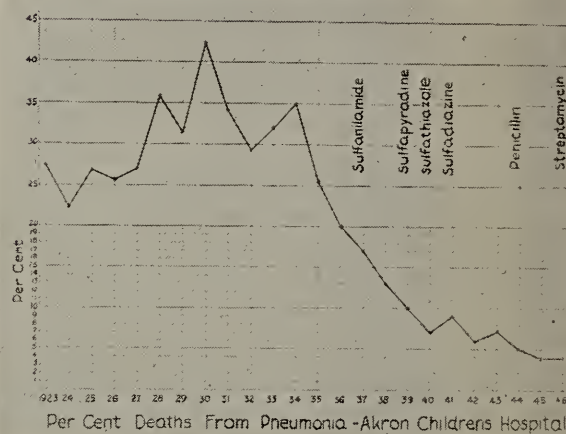


CHART V

sidered as an all-purpose drug or one that will take the place of penicillin or the sulfonamides. One should use streptomycin only after a diagnosis has been established or the infecting organisms determined.

The combined use of the sulfonamides, penicillin, and streptomycin is certainly justified if we can demonstrate that their combined action is superior to their single action; or if a mixed infection is present and one of the drugs will not suppress all of the organisms.

For example, the combined use of penicillin and sulfonamides has produced lower mortality rates in pneumonia than the single use of either

drug alone. The use of sulfonamides and penicillin in streptococcus and pneumococcus meningitis, and sulfonamides and streptomycin in influenza meningitis produce better results than when only one drug was used.

EVALUATION OF ANTIBODIES OVER 10-YEAR PERIOD

It might be well at this time to evaluate and review the effect of these new products. With this in mind the percentage of deaths at Akron Children's Hospital was determined from 1923 through 1946. Chart IV shows the graph of the percentage deaths for each year and the date each chemotherapeutic agent was available for general use in the hospital. From 1923 to 1937 the death rate varied between 4½ per cent and 8½ per cent and the last ten years gradually dropped to 1 per cent. An evaluation of the percentage deaths from pneumonia shows a tremendous reduction. Chart V: From 1923 to 1937 the average percentage death rate was about 29 per cent; this dropped to less than 5 per cent the last 10 years. In no other decade of medical history have such results been achieved and the future holds even greater promise.

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Small Intestine

Radiologic examination of the small intestine at times reveals a diffuse disorder involving the caliber, the mucosa, and the barium-transport of this organ. This X-ray appearance, though it has been given the name deficiency pattern, is found in a wide variety of clinical conditions. Its presence indicates that disorders such as sprue, vitamin B-complex deficiency, pancreatic disease, parasitic infestations, gastro-enteric anastomosis and acute infections must be considered, but at times the deficiency pattern is the result of obscure causes, possibly psychogenic. Therapy consists of liver injections and symptomatic measures. Folic acid does not appear to help unless the patient suffers from sprue.—Franz J. Ingelfinger, M.D., Boston, Mass., Connecticut State Med. Jrnl., Vol. XII, No. 2, February, 1948.

Migraine

Migraine generally reveals a hereditary factor, and the onset is usually before the second decade of life. Frequently the onset of the headache is preceded by an aura, usually associated with vasoconstrictive phenomena, which disappears with the onset of the headache and its associated vasodilatation. The headache is closely associated with nausea and frequently with vomiting. Position of the body has no effect upon the headache but exercise may increase the intensity. The headache is markedly relieved by pressure over the temporal or carotid arteries on the affected side, but immediately recurs when the pressure is released. Drugs which constrict the extracranial vessels, such as ergotamine tartrate, will relieve the headache. However, epinephrine, which supposedly should constrict the extracranial vessels does not relieve the headache but usually changes the location and increases the intensity. This may be due to its dilating effect upon the cerebral vessels.

PRECAUTION IN TREATMENT

In regard to the use of ergotamine tartrate, there are certain precautions to be observed. The largest single intravenous dose should not exceed 0.25 mg. nor be repeated more than once in twenty-four hours. The largest subcutaneous injection should not exceed 0.5 mg. for a single dose and no more than two in twenty-four hours. The number of weekly parenteral injections should not exceed two and not more than six per month. When given orally the maximum daily dose should not exceed 10 mg. or 30 mg. per week. The daily use of this drug is not recommended. Ergotamine tartrate is contraindicated in intravascular infections or obliterative vascular disease. The majority of cases will be relieved by 0.25 mg. of the drug given intravenously, but usually an equal dose is required subcutaneously before an attack is completely dissipated. The subcutaneous route is to be preferred and usually gives effective relief within an hour to an hour and a half. The patient should be instructed in self administration for the same reasons that a diabetic is given similar instructions in the use of insulin. In my experience the oral administration has not been satisfactory. However, there are many favorable reports where adequate relief is obtained by this method, particularly in those cases where nausea and vomiting are not prominent symptoms, and where the taste of the drug is not objectionable.—William C. Egloff, M.D., Mason City, Iowa, The Journal of the Iowa State Medical Society, Vol. XXXVIII, No. 2, February, 1948.

Varicose Veins

WILLIAM W. WEIS, M.D.

PERMANENT dilatations of veins due to changes in their walls are known as varices or varicosities. These varicose veins develop in the veins of the lower extremities because of an incompetency of their valves, permitting a backward flow of blood. This produces an associated abnormal pressure and stretching of the venous wall. These progressive developments result in vessel wall as well as cutaneous pathological changes.

Varices may be divided into four types: The saccular isolated type; the tortuous lengthy type of varix; the solitary dilated varix; the fine cutaneous dilatations.

Varicosities affect the internal saphenous vein of the lower extremities most frequently, statistics reporting about 98 per cent.

INCOMPETENCY OF VALVES

The primary contributing factor in the superficial saphenous circulation is the failure of function of the femoro-saphenous valve. Other valves of the venous system may also be at fault—as those lower down the leg communicating between the superficial and deep venous system.

Factors causing varicose veins other than the incompetency of valves and weakened wall structures are their position in the superficial subcutaneous areolar tissue; hereditary tendencies with many members of the same family so afflicted; occupational tendencies common to many such as motormen and policemen; pregnancy with its associated pressure on the veins from the enlarged uterus as well as the increased intra-abdominal pressure; pre-existing phlebitis with its injury to the valves of the veins and its subsequent venous dilatations.

Their development is frequently noted in early life and 70 per cent are so diagnosed between the ages of 18 and 30 years. They seem to occur rather equally divided between male and female.

Upon these points bear the importance of diagnosis as well as the method of treatment. It is essential to establish not only the degree of valvular incompetency of the superficial venous system, but also the patency of the deep system.

Obviously it would be hazardous to obliterate the superficial venous system if the blood could not return by another means.

THREE VEIN SYSTEMS

There are, therefore, three vein systems to consider, all communicating and all with their intact

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valves directing the blood flow toward the heart. The superficial system is represented by the long and short saphenous veins. The deep system is represented by the posterior and anterior tibial, peroneal and popliteal veins. Thirdly, the communicating veins connect the superficial and deep system at various levels.

The determination of patency, competent valves, etc., may be made rather simply by means of a few established standard tests.

The entire leg up to the groin is observed. Notation is made of the size, site, and position of the veins, whether cutaneous or subcutaneous. Observations are recorded as to edema, replacement fibrosis, pigmentation, ulceration, etc.

The Percussion or Schwartz test is one of the simpler standard tests of incompetency of the saphenous system. With the patient standing, one hand of the examiner is placed along the inner surface of the upper thigh and with the other hand the vein in the calf is percussed by gentle tapping with the finger. In dilated veins a wave of fluid may be palpated by the upper hand and the vein traced to the saphenous opening. This is known as a Schwartz positive test and usually demonstrates incompetency.

TRENDELENBURG TEST

The Trendelenburg test is a demonstration of reverse venous flow in the superficial system and also of the competency of the valves of the communicating veins. With the patient on his back the affected leg is elevated to empty the veins. A tourniquet is then applied high up on the thigh tightly enough to constrict the superficial veins but not the deep ones. Direct pressure may be made by firm pressure of the fingers over the saphenous opening instead of the tourniquet. The patient is then placed in the standing position while constriction is maintained. If the veins of the leg remain collapsed for 30 seconds, it is evident that the reflux of venous

blood takes place only from above—the saphenofemoral junction—that the lower communicating veins function properly. The pressure on the saphenous is now removed. If there is a rapid filling of the vein the reflux of blood is from the incompetent saphenofemoral junction. Such cases are known as Trendelenburg positive. If no reflux should occur, this is known as Trendelenburg negative.

If there is rapid filling of the veins from below on standing with the tourniquet intact, it is evident the communicating veins are incompetent, and if with the removal of the pressure from above, there is additional reflux of blood, the case is known as a Trendelenburg double positive.

PERTHES' TEST

The Perthes' test gives information as to the patency of the deep veins. The saphenous trunk is constricted with a tourniquet, and vigorous muscular exercise is carried out. If the deep veins are patent, there is not an increased pressure in the superficial veins on standing. Exercise will asperate the blood from the superficial veins, and they will be seen to collapse. This is known as a Perthes' negative. If the superficial veins do not collapse, this is evidence that the deep veins are not patent, and their pressure is greater than normal. This is known as a Perthes' positive. A practical demonstration of this test is to elevate the leg to empty the veins and apply a rubber elastic bandage from the toes to the knee. The patient then walks for thirty to sixty minutes. Aching cramp pains in the calf or foot indicate an insufficiency of the deep circulation and that the superficial venous system is compensating for the deep veins—again known as a Perthes' positive. In contrast, if the dilated superficial veins are not acting in a compensating capacity and the deep veins are not occluded, no discomfort will result; in fact, the patient may feel considerably better after these useless superficial varicosities have been collapsed. This again is known as a Perthes' negative and a satisfactory patient for saphenous resection.

MAHORN OCHSNER TEST

The Mahorner Ochsner test is primarily a test of the communicating veins and shows at what levels the incompetency of the communicating valves exist.

The tourniquet is applied at successive lower levels of the thigh and observation is made of the size of the varicosities at each level. Another way of corroborating these findings is by the Multiple Tourniquet test in which the patient lies down, elevates the affected leg to empty the veins. Then tourniquets are applied below the knee, above the knee, at the mid thigh and at the upper thigh. On standing

the lowest tourniquet is removed first, and the veins are observed for the amount of filling. As each tourniquet is removed, observations are made. It may be necessary to reapply two tourniquets at various levels to check the exact location of each perforator.

Pratt has demonstrated a modification of the test as follows. With the patient lying down the leg is elevated and the veins emptied by light massage. A tourniquet is placed sufficiently high on the thigh to close off the saphenous vein. An Ace bandage is then applied from the toes to the tourniquet. The patient stands up and the Ace bandage is slowly unwound from above down. With the tourniquet above preventing reflux of femoral blood through the saphenous valve and with the Ace bandage below compressing the remainder of the saphenous vein, a bulge or blowout indicates an incompetent communicating branch vein. Such an area is marked and is a point where a secondary ligation will be required. In a limb where there are many such blowouts a second Ace bandage is applied from above down. As the first Ace bandage is slowly removed a blowout between the two Ace bandages is so marked for resection. While in most cases there are usually only one or two such blowouts, occasionally they are multiple, and failure to remove them will result in recurrences.

Those so afflicted and predisposed should be encouraged to seek occupations which minimize standing, walking, or muscular efforts. At every opportunity the leg should be elevated and at night much good will follow raising the foot off the bed or mattress. Proper footwear and hose supporters are advisable. Some form of elastic stocking or bandage will be helpful.

INJECTION

For some years injection treatment has been used with various sclerosing solution. They have proven to be of little permanent value. Recurrences are very high and those veins so blocked afford an opportunity for other superficial branches to become dilated as well as recanalization of the original injected veins. The injections result in local phlebitis with thrombosis many times ascending as well as sloughing or gangrene at the site of injection.

Operation with or without retrograde sclerosing injection is the treatment of choice in those cases where there is no visceral basis for the varicosities and where phlebosclerosis is not too far advanced.

ONE PLAN

A plan of therapy in the indicated cases has been adopted at the Varicose Vein Clinic of the University Hospital of Pennsylvania as follows:¹

1. In varicosities of the long saphenous vein with a positive Trendelenburg test, indicating in-

competence of the valves of the long saphenous from the saphenofemoral junction downward, the saphenous vein and its uppermost branches are ligated at the saphenofemoral junction, as a primary treatment. If, after three to six weeks, large veins still remain in the lower portion of the leg or thigh, the remaining veins are treated by injection.

2. If the Trendelenburg test is doubly positive or if the comparative tourniquet test shows incompetent valves of the communicating veins of the thigh as well as of the long saphenous vein, the saphenous vein is ligated at the saphenofemoral junction as a primary treatment. Three to six weeks later, the incompetent communicating vein is ligated and excised. After another three to six weeks, whatever veins remain are treated by injection.

3. In patients who give a history of previous phlebitis, no treatment is given to the superficial veins except support by elastic stockings or bandages until at least six months after the phlebitis has subsided. If, by that time, tests as shown by firm bandages or elastic stockings indicate recanalization of the deep veins, we believe that the superficial dilatations are no longer compensatory and may be treated as simple varicose veins.

4. If there is an enlargement of the lesser saphenous vein and a positive Trendelenburg test with pressure at the knee, ligation of the lesser saphenous vein is performed in the popliteal space. Whatever veins remain after three to six weeks from the time of ligation are treated by injection.

5. Small, thin-walled varicose veins in young women, enlargements of cutaneous veins, recurrences following ligations and excisions of veins, and veins associated with arthritic pain in the ankle and knee joint are treated by injection.

INTRACTABLE CASES

There are those persistent intractable cases with their eczematous areas and surrounding intertrigo, dry, scaly, cracked pigmented skin in proximity. Leg ulcers may be persistent or follow the slightest skin injury. These may require bed rest and elevation or some type of constricting bandage such as the Unna Paste boot or similar bandage for healing.

Chlorophyll ointment applied to the ulcerative area has been effective and stimulating to healing. All cellular debris, mucous, former applications, etc., should be removed. This can affectively be done with soap and water alternating with carbon tetrachloride. The ulcer is covered with a gauze pad containing a thin layer of ointment. A fine grain one-half inch to one inch thick rubber sponge is placed over the area. The leg is then wrapped with a wide elastic type bandage starting just below the knee and wrap-

ping downward. This prevents the bandage from slipping down during the day. The sponge and gauze are firmly incorporated in the wrapping which should also include a turn or two around the foot.

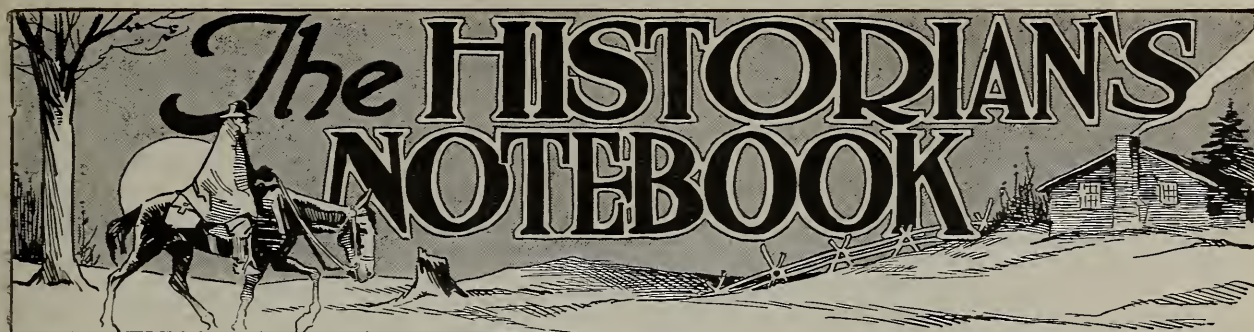
Because chlorophyll has a prolonged action, the dressing need only be changed every few days. It is well to remove the elastic bandage and sponge at night and rewrap the leg in the morning. With the leg securely wrapped the patient is encouraged to be active with extensive walking.

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Bacterial Resistance

The problem of bacterial resistance has had particular and increasing attention focused upon it. Although far from being completely understood, a few facts are available. The decrease in sensitivity may be of two types: (1) A loss or reduction of sensitivity because the organisms learn to survive despite the antagonistic substance. They develop new enzyme systems or acquire other metabolic activities as substitutes for those which the antimicrobial drug interrupted. (2) A "weeding" out of susceptible strains, leaving only inherently resistant ones. The speed with which either of these takes place varies with different bacterial species. *E. coli* in a matter of days (6 to 8 transfers). Acid-develops overwhelming resistance to streptomycin fast bacilli, on the other hand, do not become resistant for many weeks of exposure. Once resistant, bacteria rarely revert to a susceptible species. When *in vitro* observations indicate resistance, antibacterial therapy *in vivo* is probably useless. One method to avoid the disadvantages of resistant organisms rests with the use of a second antibacterial agent or a combination of two. For example, streptomycin combined with grisein or para-amino-salicylic acid allows one to hope that acid-fast bacilli will either not become resistant with their combined use or that if resistant to one, the antibacterial effect of the other will circumvent the difficulty. Let me point out, however, that this is theory only and that there have been no crucial clinical tests that substantiate this particular point. Adjustment of dose to attain maximal therapeutic benefit is also, of course, of utmost importance in this problem.—Paul A. Bunn, M.D., Syracuse, New York, Medical Annals of the District of Columbia Vol. XVII, No. 1, January, 1948.



De Spiritibus Naturalibus Et Destillatis

MARTIN H. FISCHER, M. D.

THESE paragraphs, while aimed to recite the chemical composition of the harder and softer liquors, get themselves cluttered up with psychology and narcosis. This is because under latter head they tangle with the now so popular dopes; even as under the former, they encounter the mental tortures suffered by those on hunt for drink, and of those who have tried to keep them from it (via Westerville and Hillsboro, Ohio, for example, Evanston, Illinois, or the main office in Washington D. C.).

Except in the instance of the earth's most stupid peoples, man has partaken of beers and wines since time began; his use of the distilled liquors dates from the sixteenth century. This history makes the distinction between what are the natural spirits and the harder materials now provided through chemistry. For the collector of revenue, however, the separation of the beers and the wines from the latter rests solely upon what is the percentage of ethyl alcohol in any drink. This is a mistake, we shall see. On this basis, however, a beer may be defined as a liquid which carries up to 7 per cent of this matter; a wine, one that runs to 23; a distilled liquor one that might be 100 but rarely exceeds 85 down to 43 per cent. For quiet of mind, hold 50 per cent as the average content of any ardent spirit no matter wherefrom. Stated in U. S. gaugers' terminology, this is labelled 100 proof. Russia guarantees this minimum in her present-day vodka, which in less communistic days ran better; as is the case still in the Scandinavian countries, Greece, and the mediumly civilized districts of the West Indies, Central and South America. U. S. A. has in recent years accustomed herself to a 43

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per cent, 86 proof, hard liquor in copy of British empire regulations for reasons touched upon later.

IN PRINCIPIO

Wine is the historically best known of the alcoholic drinks. It is the name of what is grape juice when left to itself. More scientifically stated, wine is the expressage of a fruit which becomes infected of an air blown yeast to convert its sugar into ethyl alcohol and carbonic acid. The ancients said that the juice "fermented" but they did not know why, until in the middle of the last century Pasteur discovered that it was live things that dropped into the blooming stuff and made it go. He called these live things, ferments, and said that every fermentative process was engendered of its specific ferment. It was thus that he came to proclaim that the various infectious diseases that plague man, other animals, and the vegetables are, too, the product of specific ferments—a declaration now phrased in the statement that the communicable diseases like scarlet fever, tuberculosis, or syphilis are each engendered of inoculation with a specific germ. This generalization regarding disease in man followed a classic of Pasteur entitled, "The Diseases of Wine and Beer", in which he set forth that these had gone wrong through infection with microscopic forms of life of undesirable character. The activator of wine is a round-shaped "animalcule" (as Leeuwenhoek would have dubbed it)

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now called a yeast. To give a grape juice good character, the yeast itself needs to be of "good" character, as we shall see.

Just when man discovered that his fruit and berry pickings affected him more agreeably if allowed to go stale than when consumed fresh is conjectural. The Renaissance found that its wine makers were only repeating practices known to the Romans and the Greeks a thousand years earlier; and after the hieroglyphics were deciphered, the Pilseners and the Münchners awoke to the fact that the Egyptians had been at the beer brewing business a full five thousand years before them. History states that the Egyptians drank a (fermented) liquid derived from a boiling of cereal long before grape-crush became the theme of song and story. In other words, first record tells of the manufacture of beer—the thirst-quenching and psychologically soothing effects of the soup garnerable from sprouted grain if dedicated to Osiris.

Beer brewing of course, has long been synonymized with what in World War I became known as "German Kultur". Anthropologically and archeologically this conclusion may not be as funny as it sounds. John Burnam taught that the Egyptians were redheads, that their rulers came out of Macedonia, that the Macedonians themselves were redheads. And where had they come from? They had trekked south-east from Central Europe. What were these Central Europeans' own hirsute appendages is revealed in the name of their great king—Barbarossa. Then recall that the Bavarian type lagers, now spread all over the world, are proud to carry this name in chief upon their escutcheons.

REGARDING THE WINE

Wine as referred to today is the fermented juice of the grape; really, wine is a generic term and covers the derivative of any kind of fruit juice. Bring to mind your acquaintance with elderberry, blackberry, cherry, peach, apricot, or dandelion wines; and then do not forget that apple juice, kept wrapped in stone, turns into hard cider which is just another member of the clan. And so is perry. All these entities are in first approximation of identical chemical composition; differing only in the perfumes they carry and in some smaller items rarely considered but to which return is made later when the better or bigger wallop of the special brands of the distilled liquors is contemplated.

Fundamental to the quality and the stoutness of any wine stand these three factors: (1) The character of the grape (meaning its virginal taste and smell); (2) the amount of fermentable sugar it contains; (3) the nature of the infecting yeast doing the dirty work.

There is no difference between a red wine and a white except in the element of skin color.

More fundamental is variation in the quantity of ethyl alcohol contained therein which in turn depends upon the amount of sugar originally in, or added to, the grapecrush. Well-nourished grapes store much sugar and so give birth to a heavy wine, while the meanly cared-for produce only the lighter. On this account the products of Spain, Portugal, and Italy hold world leadership with their 20 to 23 per cent. The decenter wines that come out of France do not boast more than 17 and usually run closer to 10; some of the Rhine wines may sink to the low of 6—which, be it noted, is the alcoholic strength of a good lager. The sugar content determines, too, whether the wine will be called dry or sweet. If all the sugar is changed to alcohol, the product is said to be dry; if some remains behind or is added later, it is called sweet. This strange antonymy is understood if the tart taste of a fully fermented wine is opposed to the blander of one still containing sugar.

BOUQUET vs. STRENGTH

Now let the generalization be introduced that real wine-bibbers do not drink their selections on the basis of their alcoholic strength—what they are after is bouquet which in physiological terms is resolvable into what tastes and smells. On this account the consumption of port or sherry is left to old ladies who while opposed to drinking do not mind taking a good "tonic"; and to the British, who knowing not good food, know not good drink either. Port, sherry, malaga, madeira, marsala, tokay are syrups so high in alcohol that nothing that can be done to them leads to their fouling. Wherefore they keep indefinitely, withstand decanting even, which, be it said at once, ruins a middle weight French wine in a day, even as mere uncorking ruins a Rhine wine in three hours. The air gets into the drink to convert some of its ethyl alcohol into vinegar and its perfumes into stink. These perfumes are fat-like compounds that give to the vegetable world its fruity and flower-like odors, but they are so sensitive to the environment that the mere addition of water, momentary contact with metal, etc., break them down. To envisage the point, imagine the taste of sweet butter alongside that of the same article gone rancid.

Every wine contains besides the ethyl alcohol searched for by the revenueurs, several others. The chemists call them the higher alcohols of which the commoner are propyl, butyl, and amyl. They are a part of the fusel oil of which the rum hounds prate, and of which more later. For the moment it should be remembered that slight change in these alcohols converts them into their corresponding aldehydes or ethers which both smell and taste differently from their mother substances. You get a bird's-eye view of what happens if you will imagine the effects

upon the smell or the taste of your wine if instead of adding to it more ethyl alcohol, you employ an equal shot of anesthetic ether. But this transformation, say from alcohol to aldehyde or ether, takes time, wherefore the allegedly higher quality of a wine properly aged. This storage cannot, however, be carried on indefinitely as is popularly believed—not over some seven years as a vintner once taught me.

The change in the bouquet of any wine is of such sensitive proportions that only artist vineyardists know what it is all about. We had them in the years before our prohibition era in New York, our own Ohio, and California. Time has gotten most of them (same as the brew masters) but enough of their blood remains to make a resurgence of civilization possible if only Federal and State Governments and the restrictors of interstate commerce (not to mention the sacred missionaries of the anti-saloon league) would lay off them. Point is that the wines now proffered U. S. A.'s thirsty millions are potentially as fine as any in the world; but stupid processing ruins them and the remaining best are not easily obtainable. What the public is offered is too largely of the red-ink, foot juice or grappo variety.

RED TAPE

It is literally easier to break out of jail than to get a known quality wine out of any of the producing fields into Ohio. Delivery here is so bound about in red tape and snarled up with state liquor board rulings (not to mention racketeers devoted solely to the diffusion of bilge) that any ordinary consumer will give up in despair.

The first and greatest enemy to quality in any wine is the air. Recall how necessary it was when you made your ceremonial wine in prohibition days to keep the cask filled and the gas outlet tube under water lest air be sucked into the fermenting mixture. We say that the wine sours. How delicate is the process is covered by the statement that a wine tasted from its domiciliary cask in a vineyard becomes something totally different if improperly tapped into a bottle. This explains why no light wine may be decanted—a type of household assault now practiced only in England and her colonies where little except the polish of the glasses used for port or sherry is known about wine. The expert vineyardist knows the principle and so does his job of transfer from home cask to vending bottle with prayer and thought. He syphons his stock into the bottles of commerce by lowering his syphoning hose to the bottom of each, allowing the wine to rise slowly about the tube until all the air contained in the bottle is thus carefully and slowly shoved out. This warmth of affection is not a part of high speed and

bottling machinery; on which account the wholesalers (as represented in wine trusts, wine associations, companies, cartels, and combines in our several states) have not yet succeeded in driving out of business the small producer. And note that the syphoning is done via a rubber hose. A Frenchman recently here, said that U. S. A. would never be able to produce a champagne the equal of his country. They still do their transferring with rubber over there and not with metal pipes, the taste of which carries over into all our products.

NAMES AND ORIGINS

Suppose we leave the American scene to consider the established wines of Europe. Besides being red or white, or heavy or light, the connoisseurs speak of their places of origin and of the year in which they were born. What does this mean? Other things being equal, the year number is only a crop number identifying the nature of the juice that was then collected. Fruits vary in their odors and tastes with the sun, the rain, the temperature, and the other conditions of their environment. But with grape juice written down as a constant, what is meant by the brands that are called moselle, rhine, burgundy, or bordeaux? These are place names; but upon them depend the dusts that carry their patriotic fervor into whatever is the grape juice of the district; and they differ widely in their politics.

God's lands carry besides their specific flowers and animals, their specific yeasts. This is a fact which we have become clear about only within this century. Formerly the grapes and the local yeasts got together haphazardly to produce the wines characteristic of their countrysides; today our fermentation scientists plan the marriage. What they have done is to isolate the most desired of the myriad of yeasts known, grow them out in pure culture and then, as necessary, inoculate them into the available grape juice. This has become standard practice. It was thus in prohibition days that it became possible for sacramental and less holy purposes to obtain dusts out of Germany which added to any proper kind of grape squeeze converted it into a red or white mâcon, a moselle or a laubenheimer.

A PATRIOTIC NOTE

This clarifies why it is so easy to reproduce any type of foreign wine in U. S. A.—a champagne in New York, a sauterne, burgundy, zinfandel or rhine in California,—not only something just as good, but as good; for our own soils yield every variety of grape and through the addition of a proper yeast, a wine unequalable. It is only the absence of the artist, the belief that mechanics is an ingredient of art and that larger profit lies in quantity rather than

quality distribution that make most easily available only what is hogwash. But quality stuff is available at many points in U. S. A. if you can get close to a real vintner and his private stock. When accomplished, all the excitement of prowling through a European wine valley and writing books about it, may be repeated here. But cooks are not chefs, and wine cannot be handled in the efficiency terms of a sewage-disposal plant.

Depending upon where you are, the wine of any country may be enjoyed anywhere along the line of its fermentation. The Swiss consume it in youngest form. They grow so few grapes that they cannot hold over for aging the yearly squeeze; for which reason they drink each season's wine crop in the hottest moment of its gestation. They call it sauzer-im-stadium and Switzerland's wine shops vie with each other in advertising the fact that they have just brought in a sizzler. It is a sparkling, therefore champagne-like, bubbling, pleasantly tart drink for any evening, with the wet feel of the newborn thing about it and is followed by only three days of invalidism. Much the same might be written of Austria's heuriger.

STILL AND SPARKLING

Most wines, however, are consumed still. This means that their fermentation has been permitted to go on until all the sugar in the system has been converted into alcohol and that the accompanying carbonic acid gas has been allowed to escape. When everything has become quiet, the product is stored in other casks or is bottled.

Were the product to be bottled while still fermenting, it would yield a sparkling wine. This is popularly called a champagne, but champagne is only a place name. A sparkling red or white wine is not, however, produced in this fashion. The original grape juice is allowed to exhaust itself as for any still wine and then is bottled. Thereafter a measured quantity of sugar is added and the container corked and wired. The new sugar feeds the fermentative fire but the carbon dioxide produced can no longer escape and so gives its sparkle to the wine. Champagne may thus be defined as nothing but a white wine charged with carbon dioxide, but the product prepared as described is a far, far different thing from that derived by taking a white wine and charging it directly with soda-fountain gas as is common practice. The problem is identical with what appears in beer manufacture, where, too, that taken directly from the keg is a tenderer thing than that which was previously boiled, bottled, and then recharged.

WHAT IS BEER?

As stated, wine is the product of the fermentation of the sugar in some kind of fruit juice.

Change the origin of the juice to some kind of a sprouting cereal and you have the groundwork for a brewery. Barley is the cereal most often mentioned though this is only because it is the ground crop of middle Europe, and cheap. Rice is frequently added, as, maybe, wheat. It is the last named which gives character to weissbier—really a corruption of weizenbier—and to what the Leipzigers used to drink as gose. The constantly cited hops in beer is just so much perfume; every other type of spice has been tried, as witness the various bitters; and the British still overcondiment with ginger.

To attempt distinction between what is wine and what is beer is useless. What the Chinese and Japanese call sake (rice wine) is really a beer; and the pulque of the Mexicans, as the product of a plant juice, is really a wine. But do not let the etymologists get you down, for the government gaugers correctly bracket the two. Shortly we shall have to classify what is extracted from the mashes—of corn, potato, and rice; or from the juices derivable from the stems, roots, or leaves of divers plants—out of which the distilled liquors are produced. It makes no difference in the product whether you call the mother liquor a beer or wine or as derived from a cereal or a fruit.

LAGER BEER

Beer has been made from all the seeds out of which you can extract photographic starch paste. Most popular is one called lager beer. I weep the death of steam beer which forty years ago comforted the laborers of our Western coast. Its only surrogate was the home brew of prohibition days with which the English porters and stouts are to be classed. Steam beer was a wild and foaming form of suds more quickly compounded than the steadier lager. It was too vicious to be bottled and so was dispensed only from the keg. Chemically it might be rated with Switzerland's sauzer; and pharmacologically, ditto.

The designation of America's most popular beer as a lager beer imposed upon it a Germanic imprint. Unquestionably this had much to do with the swelling hate that led to World War I and the advent of the 18th amendment. What does the appellation really mean? It is commonly translated, aged, yet this is not the essence of the matter. Steam beer, home brew, and the miserable stouts and porters are rapidly fermented cereal decoctions; the lagers are those brought to maturity more slowly. To produce the former requires three days; a lager, with which some of the pale ales might be classed, takes thirty to forty. It is the temperature at which the fermentative reaction is allowed to proceed that has so much to do with what comes

out. Home brew and its congeners are encouraged behind the stove; lager beer is produced in vats in halls maintained at near freezing. If you want scientific statement as to why the difference between the two, it is this: decomposition of the cereal extract by specific yeasts is what is desired; accessory decomposition brought about by also-present bacteria, is not. Cold separates the two, the yeasts being able to take it; but not the bacteria. But since cold reduces the rate of every fermentation the sugary solution that is to become lager must spend a month at the business of just settin'! But it explains, too, the clean taste of a good lager and the mustiness, muck and cloy of all the others.

BOTTLES NO IMPROVEMENT

Forty years ago lager beer was dispensed to the public chiefly via a good saloon or a tin can. Change to the standards of today has increasingly replaced this older draft beer by the bottled variety. The transition has not been made without spiritual loss. The best that can be said for bottled beer is that any kind of canned goods is superior to none at all; but it is not superior to the original. Tapped as is, from the vat or from the oaken barrels into which in older days it was drawn raw, lager beer is a carminative, thirst-quenching, food-containing, vitamin-rich drink able to do several things for man besides lift him out of his Anglo-Saxon manic-depressive insanity. There is no use in going into its quick energy-yielding values, its soothing effects upon the mucous membrane of the irritated stomach, its appetite-evoking qualities and its growth-promoting principles, all without large risk of drunkenness. (I disagree, obviously, with Kraepelin, the German, who thought that his Münchenerers went crazy because they sat too long in the Bier-Kellers; and with Bunge the Swiss, who took alcoholism so to heart that he personally met arriving trains with tea to distract the dry-throated arriviers from their desire for beer.)

The decline of the service to us of beer on tap (better maintained by the Mexicans who still dispense their unequalled brews de barril) needs this comment. The transfer of the mother liquor from its wooden containers to a bottle, is a violence. A barreled beer is something still alive and working, and cannot, therefore, be bottled without blowing up. On this account it must first be killed by boiling. But such treatment sends not only the still active yeasts to heaven, but blows off its champagne-like quality. This is caught in carbon dioxide tanks and later pumped back into the flattened remains. Unfortunately, this is not a reversible reaction.

Bottled beer is to keg beer as corned beef is to a freshly broiled sirloin.

WHAT IS FIREWATER?

We owe the discovery of what the doctors, the pharmacists, and the pharmacologists call spiritus frumenti or spiritus vini gallici, with their many aliases, to a 16th century Dutchman. He wanted to concentrate the virtues of wine and to this end applied to it the principle of distillation—the great truth that any two liquids may be separated from each other if they boil at different temperatures. By this invention he separated the spirit of wine, today called its alcohol, which boils at 78 degrees from its watery partner which does not boil until 100 degrees.

Necessity lay behind this invention. Dutchmen were sailing the world's seas and courage (what we call morale today) in storm lay quickest to hand in the flagon. But wine is a bulky affair and the mariners of the moment wished for something just as good that did not so obviously diminish cargo space. Could not the essence of wine be captured which even if not so mouth filling would at least be equally potent in pushing the consumer into a lowered state of nervous receptivity. The answer was, yes.

As the product of fire, the distillate from wine was rightly dubbed burned wine, or in the original brandewijn or branntwein. British imperialism (which changed the name of Firenze to Florence and of Livorno to Leghorn) corrupted this Flemish, to brandy; and French passion for the county insisted that it be called cognac. In any man's language it is in round numbers a fifty per cent solution of alcohol, on the gauger's scale something 100 proof.

RUM

After the Dutch had invented brandy and the chemist laureates of the period had discovered that it was just the sugar in grape juice that gave it its fever, lots of other vegetable decoctions came to be used as source materials. First star for achievement again went to the Dutch. Their intrepid traders had come upon the sugars of the whole world, more particularly upon those derivable from the canes. When cane juice is boiled down, what is called cane sugar crystallizes out and this is what the Dutch used to sell into Europe in their huge, cone-shaped blocks. But not all the sugar contained in cane juice will thus crystallize out, in fact as much as the half thereof may remain behind. When of high grade, it is sold as syrup; lower grades are called molasses, the lowest member being known as blackstrap. Trust the frugal Dutch—and later the careful Scotch—to find a useful end for this waste. If not molested, the sugar of cane goes to alcohol, and distillation which makes

brandy out of wine, makes rum out of molasses. Since the first of the canes stemmed from the West Indies, it is not surprising that one of the first of the rums should have been baptized, Jamaica.* But she is only one of a large family. We now have with us the rums of Cuba, Puerto Rico, and the Virgin Islands, not to mention those of the continental districts of Mexico, the South American states, and Brooklyn and Boston. It was thus that it came about that brandewijn, which first eased the long voyage out, was replaced by rum for the long voyage in. Also it is made apparent why courage on the sea is so often referred to as Dutch courage.

But brandewijn and rum as inventions of the Dutch could not indefinitely be held within these narrowly nationalistic hands. All the sovereign states of Europe, aided by their colonies, went into their manufacture, advancing science by their going into the manufacture of spirit from their own more native vegetable stocks. Whence the origin of applejack and perry; and apricot, peach, and blackberry brandies. From rye mash the Russians then prepared vodka; and from this and other cereals, the Germans, Schnapps. The Scandinavians derive from their mashed potatoes, akvavit. The century plant and its roots produce mescal and tequila for the Mexicans; and the Peruvians distill what is called pisco from one of their native perennials. Britain first and then ourselves produced just gin. Originally this was the cognomen of any fifty per cent ethyl alcohol derivable from any still; since which time it has been flavored up with juniper; or, by the Dutch, with the sloe berry (the plum of blackthorn). When the newly found Indian corn of the American colonies came to be a large constituent of the mash out of which a gin was distillable, we got American whiskey, a manufacture once identified with the states of its origin but now so refined that the counties are mentioned. Bourbon whiskey was not only American and Kentucky whiskey, but that from Bourbon county. Today, of course, you get it from anywhere along the drainage basin of the Ohio Valley.

AFTER-TREATMENT

As born, all these liquors are water-white, and possessed of a burning or stinging taste. Except for some after-treatment (only partially curative) these legally accepted standards differ in nowise from what in other circumstance is corn liquor, white mule, mountain dew, moonshine, or, to get to the latest fancy, "pure neutral grain spirit". More plainly stated every fifty per cent alcoholic distillate from any kind of fruit, vegetable, berry, grain, or God-what-have-you, is somebody's bottled patriotism. As whiskey it underlies the American Constitution; and as some

kind of insanity or hobnail liver producing gin, all other white-mandated quarters of the globe. The cereals, tubers or fruits available in any land make small difference, every country having for centuries past employed for the "mash" anything containing starch and sugar lying nearest to hand. On this account the Eastern Europeans ran to barley and wheat; the yellow races to rice; we, to corn. The Scandinavians use the potato straight; and the Scotch and Irish, this plus barley with a sock of molasses.

CUSTOMER CHOICE

It is only in the game of advertising and self-hypnosis that these essentially like products, compete. One enthusiast insists that his drink must have had a pinch of rice added to the corn; another, that for him the mash was soaked in a calcium-rich water; a third, that the original distillate was stored in "charred oaken barrels". Yet every trader stores his rotgut in oaken barrels, for if kept in softer woods, too much of their rosins are taken up by the liquor, thus more violently to strangle the customer. What the man gets who insists upon scotch is a bit of creosote out of the tarred wood; those who cry for irish, are calling for lactic acid which is what makes ill-tended babies smell so bad; and those who cackle about the fruitiness of their drink are enjoying the odors of shoe polish.

The term, "pure neutral grain spirits", needs thought. Since it makes up sixty-five or more per cent of today's available bourbons, American irishes and scotch, just how much remains in the bottle to be straight whiskey as defined by the Pure Food and Drug Act? Well, anything that comes out of a still is pure, if you do not say pure what; and the designation, grain, is legitimate if it is to distinguish this historically tried out method from the production of ethyl alcohol in cleaner form from coke over gases; and spirits is good if the plural means that what is being offered is not ethyl alcohol alone but a mixture of several alcohols. The designation, neutral, is just plain silly, for most distillates are acid in reaction and desired because of their (fatty) acid flavor.

GIN ALCHEMY

The mash from which any spirituous liquor is distilled carries besides ethyl alcohol, several more. These rate "higher" in boiling point, chemical structure and knockout. The distillers have always been at pains to tame these wilder elements, but in spite of honest care, they will pass over into the distillate and once thus freed, are not easily shot. The accurate distillation of any volatile (in this case ethyl alcohol from its accompaniers) calls not only for great scientific sense but for a willingness on the part of the distiller to lose much money. The rules of dis-

tillation require that after the first quarter of what passes over has been discarded, the last quarter, too, be dumped down the drain. This is a heartlessness toward the mash which we fear is not a part of the commercial engineer. Wherefore, the temptation to ignore chemical law and to try to get rid of the fester, later. Two lines are followed: some kind of dope is added to the raw spirit and/or those famous charred barrels are relied upon to suck the undesired elements in the gin, out of it.

The situation explains why nobody is today drinking straight whiskey but only something called a blend. It is the name of real whiskey which by one or another method has had some of its teeth drawn. As Harvey Wiley said forty years ago when our Pure Food and Drug Act first went into effect, "pure" whiskey (then defined as a distillate from cereals, etc., stored for seven years in charred oaken barrels) was still something so raw that the thirsty souls of the Gridiron Club in Washington, D. C., would not drink it. It made the whiskey blend legal and the now accepted in U. S. A. (This reformation owes much to Cincinnati, for it is mainly out of this town that the original law was modified. President William Howard Taft by executive order, declared the blends pure whiskey. Do not think that there was anything criminal in this, for 90 per cent of all whiskey had been blended for decades before the Act ever turned up.) Something has to be done to soften up any original red likker. Mere dilution with water does a part of the job and explains why the theoretical 200 proof job rarely runs over 100. Most of today's whiskeys are stabilized at 86. This step toward morality we owe to the Presbyterians, Methodists, the Church of England, and to the tax assessors in the British Isles. They have a graded tax on concentration over there, which allows 43 per cent ethyl alcohol to get by with a lower allocation to government revenue than any higher proof stuff. But the descent is not likely to go lower. This is because the taste of any liquor neat, depends upon the fact that its alcohol is on the outside of a mayonnaise-like mixture with water, and that it cannot be further diluted without killing it. Scientifically, 33 per cent is the lowest possible limit before water becomes the outer phase and is then tastable as water and not as whiskey any more.

The 43 per cent alcoholic structure of the imported whiskeys explains why formerly so many Americans alleged that they could drink scotch but went drunk on bourbon. A 14 per cent reduction in alcoholic content delays any man's pace to the asylum! Reduction of the poisonous qualities of any hard liquor can, however, be brought about—and once was—by subtler means. A goodly portion of sherry, madeira, or mar-

sala wine does the job which besides diluting, smooths things out. Another attempt to take the fire out of firewater resides in storage for several years in those famed charred barrels. These suck things out of the mule even as they contribute color and other things to the animal. The chemical changes involved have been given the closest study, wherefore we have on hand today quicker means to the sought-for ends than a half century ago. A proper dope may nowadays color, soften, smooth, and age by seven years the hardest of any still's worm products in a night! All that is required is a university graduate in chemistry who knows what are caramels, peroxides, adsorbents, and the essential oils.

ALCOHOL AS ANESTHETIC

If it is believed that any spirituous liquor has value only in proportion to the amount of ethyl alcohol it contains, straight alcohol (something 200 proof, in other words) should ever have been the standard of any O.P.A.'s rulings. But only the doctors and the Swedes have ever had the courage to dispense this compound. Without getting funny, pure ethyl alcohol is one of the best of the anesthetics known to man as revealed, for example, in the fact that in former years it constituted one third of the then so popular A.C.E. mixture. This was a mixture of ethyl alcohol, chloroform, and ether and was used because then known as the safest of inhalation narcotics.

The merits of dilution of our once stronger liquors to the 86 proof standard derive from England and were taken over by us only recently. Aware of the evils of intoxication but more aware of the evils of prohibition (the era which invented jakeitis and almost doubled the number of alcohol charges in every hospital and strong ward in our land), Yandell Henderson wanted 4 per cent beer brought back, a concentration of alcohol which even on continuous consumption yielded no measurable physiological effects. When beer did come back, strong drink came along too, on which account this great physiologist became proponent of the British ideal of the weakened whiskey and wrote a book on the subject.

The red tongue of hard liquor has long been called fusel oil. It needs this bit of emendation. It is a name that covers what besides ethyl alcohol is distillable off any fermented mash. Let it be repeated that its chief and most potent elements are things like propyl, butyl, and amyl alcohols. If rum is your drink, observe that the rum-raising districts of the tropics frequently add extra labels to assure you that by chemical analysis the contents of your bottle have been found "free from amyl alcohol". This was not the case for the gins of older days in our country

where what the consuming public designated mountain dew, nigger gin, and sheeny booze carried as much as 1 per cent of this material. This is so important because the anesthetic, better said the narcotic knock-out, receivable from pure ethyl alcohol lasts only a few hours; that from these higher alcohols, as much as two days.

BARBITURIC ACID.

In the early years of this century, Emil Fischer, on search for a sleep producer less poisonous than the morphines, invented veronal (called barbituric acid by us to outwit the international patent laws after we suspended them in World War I). It is a nitrogen compound which when taken into the body is converted into an alcohol-like compound and urea. The latter is a harmless excrementitious material such as is produced in the digestion of all meats; the first, the equivalent of the soporific element found in pure ethyl alcohol. But leave it to the boys! Our intrepid manufacturers and chemists have substituted for the ethyl alcohol-like material in the original barbituric acid, propyl, butyl, and amyl, thereby in each case stiffening the uppercut. I won't add that they have put in even carbolic acid which is the heavyweight champion (and intended to quiet even the maniacs and the epileptic). So what is the significance of fusel oil in any of the so-called bad whiskeys? Obviously, if hospital effects are what you are after, bad American whiskey (and every like product from distant land) is not really bad, but the best!

Electioneering propaganda lies in all this. Our Union has set forth its right to control the manufacture, distribution and sale of the narcotics (things like heroin, morphine, cocaine, etc.). All that a resurgent Methodist, Woman's Christian Temperance Union, or Anti-Saloon League needs to do to bring in another era of prohibition is to get it established legally that the harder types of the spirituous liquors are of that class.

IN NUCE

I hope that the facts have made it clear that up to the time of the here-mentioned Nordic alchemists, drinking as we call it today operated on one cylinder only and almost entirely in low gear; and that the mightiest of the engine fuels did not exceed a stout wine. By corollary and if the negative in history may be believed, sousing as we know it today did not exist. The Egyptians say nothing of drunkenness and much the same may be recited of the Greeks who while recognizing it, seem never to have become acquainted with its vicious stage. The discovery of brandy and like compounds changed all this. There is little in the literature preceding 1600 which portrays the horrors of inebria-

tion. Falstaff consumed too much sack, and Danton said that when he sank, it would be in port; but neither Shakespeare nor Dickens, with a dozen Greek, Roman, and Arabian authorities thrown in, ever pictured delirium tremens, peripheral nerve paralysis, or cirrhosis of the liver. That was left to Hogarth and his "Gin Alley" and the "Progress of the Rake". Brandy marked the transition from the wine that Jesus professed at Canaan (a something that may be imagined to have run 10 per cent ethyl alcohol) to the hard boiled stuff now so necessary in the nourishment of the young. Thus became fixed the great gulf that separates the beer and wine bibbers of ancient days from what are the rum hounds of the atomic age.

AMERICAN COCKTAIL

Into the early years of this century even, the American was essentially a consumer of beer and wine only; not that he was unfamiliar with stronger stuff as the institution of distilleries in every mill town of the expanding Western frontier proves. But even as late as 1900 ardent spirit taken neat or with a chaser as represented in the "boiler-maker and his helper" was a rarity. Wine was the strong drink of Delaware, New York State, Ohio, and the West Coast. It required the invention of the cocktail (an entirely American produced mechanism) to make swallowable the hard liquors available either domestically or by import, which be it said is nothing but two thirds of any kind of distilled liquor diluted with one third water, plus some kind of flavor to kill the mother taste, and ice, to reduce the speed of its lightning. It is a freshly made cordial which if you desire it, you may order straight—the cordials are all of them mixtures of fifty per cent sugar with fifty per cent alcohol and some kind of flavor thrown in. Most popular is the oil of orange, but apricot goes very well, with peppermint or pine desired by some.

If lesson must be drawn from this discourse, then what is it? Obviously, if the purpose of drinking is to get drunk, that end is subserved most rapidly by demanding gin, bourbon, scotch, irish, akavit, rum, mescal, tequila, or vodka. If without this ambition, order wine. If you are without taste, call for sherry, port, maderia, malaga, or marsala; if you have appreciation, ask for Burgundy, Macon or Bordeaux. Coyest are the rhines, alsatians, and champagnes but do not believe that any of these are unobtainable in U.S.A. If you haven't the price, consider beer. It is the poor man's champagne, which comes in best dress out of the local saloon, where if it is your luck, you will find it on tap out of a barrel.

Ohio Points With Pride to Cleveland's Five Heads Of National Specialties Groups

OHIO has always taken pride in the number of its medical men and women who have distinguished themselves and in turn have been honored with offices in national and international organizations. This year high honors go to the Academy of Medicine of Cleveland, five of whose members, within little more than a year, have been honored with the presidencies of specialty organizations.

Dr. John A. Toomey is president of the American Academy of Pediatrics, representing pediatricians of the Western Hemisphere. Dr. Toomey is professor of clinical pediatrics and contagious diseases of Western Reserve University School of Medicine, and physician in charge of City Hospital's contagious disease division. He is a native of Cleveland and received his degree from Western Reserve University School of Medicine.

Dr. Clyde L. Cummer is the new president of the American Academy of Dermatology and Syphilology. He is a past-president of the Ohio State Medical Association and of the Academy of Medicine of Cleveland, and is a former chairman of the section on dermatology and syphilology of the A.M.A. Also he is a former member of the A.M.A.'s Council on Scientific Assembly and former chairman of the Committee on Education of the Ohio State Medical Association.

Dr. Edgar P. McNamee is president-elect of the Radiological Society of North America. A native of Butler, Pa., he received his degree from the University of Pennsylvania School of Medicine. Dr. McNamee has practiced medicine in Cleveland since 1915, except for a period during World War 1 when he served with the Army Medical Corps in France. He is the immediate past-president of the Ohio State Medical Association, member of the Cancer Committee of the Association and of the A.M.A. Committee on Veterans Administration Affairs.

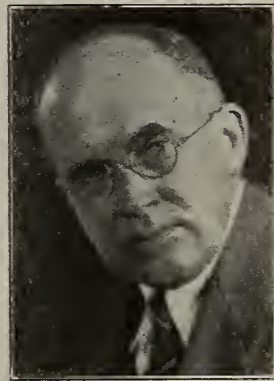
Dr. Charles C. Higgins is president-elect of the American Urological Association. Dr. Higgins is surgeon of the urological department of Cleveland Clinic. He received his degree from the University of Washington, Medical Department, and has practiced medicine in Cleveland since 1923. During World War I he was in the Air Corps.

Dr. Roy W. Scott recently completed a term as president of the American Heart Association.

He is professor of clinical medicine at Western Reserve University School of Medicine, from which he received his degree, and is physician in chief at City Hospital.



J. A. TOOMEY, M. D.



C. L. CUMMER, M. D.



E. P. MCNAMEE, M. D.



C. C. HIGGINS, M. D.



R. W. SCOTT, M. D.

Polio Facts Available

The 1948 edition of "Facts and Figures About Infantile Paralysis", is now available to physicians and public health workers. It may be secured free of charge by writing Education Service, The National Foundation for Infantile Paralysis, 120 Broadway, New York 5.

Analysis Made by V. A. Contains Helpful Tips Regarding Premedical Training for Prospective Students

THE Veterans Administration has advised ex-servicemen planning to enter medical school under the G.I. Bill or Public Law 16 that they stand a better than average chance of completing their training successfully if they obtain grades of B plus or better in their premedical training; make particularly high grades in the natural sciences; and enroll in medical schools in the same educational institutions in which they completed their premedical work.

The V.A. states that these conclusions are based on a compilation of various published studies which have been made of the records of medical students in various sections of the country.

WEAKNESSES REVEALED

The comments of the V.A. are of considerable importance as they reveal the vital role which premedical training plays in our entire system of medical education, indicating in some instances that there are some glaring deficiencies, at least in keeping premedical work in proper balance. Also the studies show quality of premedical training is far more important than length of training.

One study quoted disclosed 99 per cent of all failures during a 10-year period were students whose premedical grades averaged below B plus. Another study revealed that average grades for medical students during the first three-quarters of their professional training was about 6.11 percentage points below their premedical averages. Based on this study, it is concluded that a veteran with merely fair premedical grades would have but a slight chance of successfully completing medical school, the bulletin points out.

In predicting medical school success on the basis of grades received in natural science courses, V.A. emphasized that the quality of work in such courses, rather than the quantity of science courses studied, is the important factor.

FALSE SENSE OF SECURITY

Many students who take every undergraduate science course available "develop a false sense of security by assuming that the pursuit of extensive work in the sciences necessarily places them in a better position to cope with medical school work," the V.A. study observed. The findings disclosed that students who attend medical schools in the same educational institutions where they took their premedical training consistently make better grades than students who transfer from other schools. The percentage of

failures of "native" students also was appreciably lower than for transfer students.

"NATIVE" STUDENTS SUPERIOR

V.A. explained the consistently superior accomplishments of "native" students by the fact that medical schools, able to consult personally with premedical faculty members about the qualifications of applicants, are in a position to select those applicants most likely to succeed.

The V.A. bulletin cautioned that scholastic aptitude tests and the length of premedical training—when considered without relation to other factors—are unreliable in evaluating chances for success in medical school.

TESTS NOT DETERMINING FACTOR

In one case, scholastic aptitude tests were administered to 1,000 prospective medical students. The tests correctly predicted successful completion of medical school only 53 per cent of the time. In fact, 5 per cent of the students whose classroom averages were among the highest made poor showings in their aptitude tests. The tests are of greatest value when utilized as supplements.

Although each year an increasing number of medical schools limit admittance only to students with bachelors' degrees, research studies have indicated that the length of premedical training has little bearing upon their future accomplishments in the study of medicine.

TIME NOT ALL-IMPORTANT

One study showed poorer medical school results from students with bachelors' degrees than for those with three to four years of premedical training who did not obtain degrees.

Another survey reported that the average four-year grade of medical students with two years of premedical training was 82.8; for those with three years of premedical training, 81.9; and for those with four or more years of undergraduate work, 82.1.

The V.A. study concludes that the quality, rather than the extent of college preparation, determines eventual performance in medical school.

Accidents Cost 7 Billion

The 1947 report of the National Safety Council shows that one out of every 14 persons in the United States suffered a disabling injury during 1947 with a total cost in wages, medical expense, and property of nearly seven billion dollars. Injuries occurring in the home exceeded every other classification.

Licensed Through Endorsement By State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

October 14, 1947—Warren E. Bradbury, Tiffin, Chicago College of Medicine.

December 12, 1947—Benjamin Abrams, Cleveland, Northwestern Univ.; Henry C. Benzenberg, Jr., Pickaway County, Long Island College; John A. Billows, Delta, New York Med. College; Robert Brill, Cincinnati, Long Island College; Glenn D. Crook, Cincinnati, Univ. of Nebraska; John A. Davidson, Springfield, Univ. of Vermont; Nicholas J. Ellis, Delta, Marquette Univ.; Merrill D. Evans, Massillon, Univ. of Kansas; Leonard B. Goldberg, Cleveland, St. Louis Univ.; Arnoldus Goudsmit, Youngstown, Univ. of Amsterdam.

Nathaniel R. Hollister, Yellow Springs, Univ. of Nebraska; Donald A. Koch, Toledo, Wayne Univ.; Simon Koletsky, Cleveland, Yale Univ.; Robert H. Kooiker, Cincinnati, Univ. of Iowa; Robert B. Kubek, Cleveland, Duke Univ.; Albert A. LaLonde, Cleveland, Univ. of Texas; James M. McCord, Columbus, Univ. of Michigan; Hugh J. McVeigh, Dayton, Univ. of Michigan; William Newcomer, Youngstown, Med. College of Virginia; Joseph A. Provenzano, Toledo, Univ. of Illinois; Dudley B. Reed, Oberlin, Columbia Univ.; Richard C. Schneider, Cleveland, Univ. of Pennsylvania; Woodrow W. Scott, Portsmouth, Med. College of Virginia; George W. Smith, Jr., Akron, Rush Med. College; Andre R. Tweed, Cleveland, Howard Univ.; John L. Tyler, Cincinnati, New York Med. College; Ralph E. Vitolo, Cleveland, Loyola Univ.; William W. Wallace, Dayton, Univ. of Arkansas; Joshua H. Weiner, Columbus, Long Island College.

January 6, 1948—Eric Bell, Jr., Cleveland, Vanderbilt Univ.; Willard D. Boaz, Cleveland, Univ. of Pennsylvania; Francis C. Boyer, Columbus, Univ. of Louisville; Robert R. Cadmus, Cleveland, Columbia Univ.; John M. Dasher, Jr., Toledo, Meharry Med. College; Thomas J. Dring, Dayton, Cornell Univ.; Frederick A. Friedrich, Youngstown, George Washington Univ.; Samuel Goldenberg, Cleveland, Univ. of Louisville; John F. Grant, Dayton, Loyola Univ.; Theron L. Hopple, Toledo, Univ. of Chicago; Huldric Kammer, Cleveland, Northwestern Univ.; John J. McLaughlin, Cleveland, St. Louis Univ.; Ralph R. Minges, Cincinnati, Univ. of Louisville; Don C. Nouse, Toledo, Univ. of Michigan; Emmett J. O'Malley, Cleveland, Georgetown Univ.

Hugh W. Payton, Jeffersonville, Univ. of Oklahoma; Paul Q. Peterson, Columbus, Univ. of Illinois; Wayne H. Pitcher, Portsmouth, Northwestern Univ.; George E. Rabinowitz, Cleve-

land, Univ. of Texas; David H. Ross, Cincinnati, New York Univ.; William B. Settle, Zanesville, Meharry Med. College; Sam G. Stubbins, Cleveland, Long Island College; Harold R. Tharp, Cincinnati, Indiana Univ.; Andrew E. Thuesen, Cleveland, Creighton Univ.; Gerard I. Uhrich, Dayton, St. Louis Univ.; William D. Welton, Jr., Dayton, Univ. of Rochester; Cuthbert R. Yolton, Apple Creek, McGill Univ.

Hospital Births by Counties Show Wide Variation

Wide variations in the per cent of hospital births to women of the separate counties of Ohio are shown by the November *Ohio Hospital Survey Bulletin*. In Lake County, 98.6 per cent of the women had their babies in hospitals, whereas in Vinton County only 17.4 per cent of all accouchments occurred within hospitals.

The ten counties with the lowest percentage of hospital births, from low to high, were Vinton, Adams, Pike, Monroe, Jackson, Fayette, Madison, Meigs, Clinton, and Brown. In none of these counties is there a general hospital with a maternity service.

There also is a variation in the hospital consciousness of different communities. In Auglaize County with no hospitals, 87.8 per cent of infants were born in hospitals in 1946, and in Morrow County, also without hospitals, the percentage of infants born in hospitals was 89.

In 1946, the percentage of infants born in hospitals for the State as a whole was 90.2.

Preventive Medicine Board Named

Formation of an "Interim Board" of Preventive Medicine recently was announced from Washington jointly by the Surgeons General of the Army, Navy, and U. S. Public Health Service. The board was formed chiefly for the purpose of setting up certification requirements for medical officers seeking to qualify as specialists.

"The cooperative effort of these three services will undoubtedly give impetus to a growing demand for creation of an American Board of Preventive Medicine and Public Health to take its place along with the 16 medical specialty boards," the announcement stated. The board consists of six civilian doctors, chiefs of the preventive medicine divisions of the Army and Navy, and an officer selected by the Surgeon General of the P. H. S.

Sterility Group To Meet

The American Society for the Study of Sterility will hold its fourth Annual National Session June 21-22 at the Congress Hotel, Chicago. Information may be obtained from the Secretary, Dr. John O. Haman, 490 Post St., San Francisco 2.

New Members Added to Roster

FOLLOWING are the names of new members of the Ohio State Medical Association, since January 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY
F. Miles Flickinger, Lima
T. J. Talbott, Bluffton

ASHLAND COUNTY
Robert J. Ferguson, Ashland

ASHTABULA COUNTY
Donald W. Crittenden, Andover

AUGLAIZE COUNTY
W. F. Schmiesing, Minster

BUTLER COUNTY
John L. Bauer, Middletown
Charles H. Buchert, Middletown
Carl A. Leyrer, Hamilton
John R. Perkins, Middletown
Byron E. Swaine, Middletown

CLARK COUNTY
Sidney J. Glueck, Springfield

CRAWFORD COUNTY
Martin H. Vinkel, Crestline

CUYAHOGA COUNTY
Nelson Adelstein, Cleveland
Paul H. Bade, Cleveland
Robert R. Bartunek, Shaker Heights
Robert E. Bennett, Cleveland
Harold B. Bilsky, Cleveland
Joseph E. Brown, Cleveland
Charles H. Herndon, Cleveland
A. Beaumont Johnson II, Cleveland
Edwin P. Jordan, Cleveland
Henry E. Kleinhenz, Cleveland
Robert C. Little, Cleveland
Harold V. Marley, Cleveland
James Franklin Martin, Cleveland
Jerome H. Meyer, Cleveland, (temporary address, Dayton)
D. P. Mitchell, Cleveland
John A. O'Hale, Brecksville
Milton M. Oppenheim, Cleveland
Carl J. Pfahl, Cleveland
Howard E. Possner, Cleveland
William T. Sweeney, Cleveland
Jack L. Whitaker, Cleveland

FAIRFIELD COUNTY
William M. Kuntz, Millersport
Arthur E. Van Gundy, Lancaster

GALLIA COUNTY
J. Gordon Gibert, Gallipolis
Edwin Ragnar Irgens, Gallipolis

HAMILTON COUNTY
Robert Brill, Cincinnati
William D. DeVaux, Cincinnati
Bernard C. Dienger, Cincinnati
F. Paul Duffy, Cincinnati
Richard A. Hoffman, Cincinnati
Aaron A. Katz, Cincinnati
John D. Lauer, Cincinnati
Charles E. Work, Cincinnati

HARDIN COUNTY
E. J. Clinger, Forest
Wm. D. Dewar, Kenton

HENRY COUNTY
William R. Ward, Holgate

JACKSON COUNTY
Earl J. Levine, Wellston

JEFFERSON COUNTY
Stephen L. Hadobas, Steubenville

LAWRENCE COUNTY
John A. Dole, Jr., Ironton

LICKING COUNTY
Carl L. Petersilge, Newark
James H. Pollock, Newark

LOGAN COUNTY
Thomas G. Petrick, Belle Center

LORAIN COUNTY
Robert Warren, Oberlin

LUCAS COUNTY
Paul L. Bell, Toledo
Charles Bohnengel, Toledo
Myron Fink, Toledo
Norman G. Mathieson, Toledo
A. B. Saeli, Toledo
Daniel S. Wolff, Toledo
R. L. Zucker, Toledo

MAHONING COUNTY
Nathan D. Belinky, Youngstown
Andrew A. Detesco, Youngstown
Herbert B. Hutt, Youngstown
Robert M. Kiskaddon, Youngstown
Elmer T. McCune, Sebring
James D. Miller, Youngstown
Stewart G. Patton, Jr., Youngstown
Alexander K. Phillips, Youngstown

MARION COUNTY
William H. Whitehead, Marion

MEDINA COUNTY
Wm. Edward Dwyer, Jr., Medina

MERCER COUNTY
John W. Chrispin, Rockford

MIAMI COUNTY
Roger N. Gove, Piqua

MONTGOMERY COUNTY
William B. Ayres, Dayton
Delatus E. Brown, Dayton
William S. Clark, Boston, Mass.
Stanford J. Coleman, Dayton
Dean C. Elliott, Dayton
Charles E. Richards, Jr., Dayton
Robert P. Stafford, Dayton
William J. West, Dayton

MUSKINGUM COUNTY
George T. Thompson, Philo
Donald A. Urban, Zanesville

OTTAWA COUNTY
Harriet B. Howes, Port Clinton

PIKE COUNTY
Charles A. Clifton, Pike-ton

PORTAGE COUNTY
Richard C. Neely, Jr., Ravenna
Stanley B. Peters, Kent

PUTNAM COUNTY
Carl J. Heitz, Fort Jennings
Donald B. Lucas, Columbus Grove

RICHLAND COUNTY
Charles F. Curtiss, Belleville
Fred O. Tonney, Mansfield

ROSS COUNTY
Elsa Klein, Chillicothe

SANDUSKY COUNTY
Frank G. Olah, Bellevue
Henry James Wynsen, Fremont

SENECA COUNTY
Robert C. Cahill, Attica

STARK COUNTY
Edward A. Hill, Beach City

William A. McCrea, Alliance
Paul E. Wasson, Canton

SUMMIT COUNTY
Arthur William Friend, Akron
Harold E. Muller, Barberton
Marshall J. Pierson, Jr., Cuyahoga Falls

TRUMBULL COUNTY
William E. Goodman, Warren
Esther E. Sullivan, Newton Falls

WASHINGTON COUNTY
Donald S. Williams, Marietta

WOOD COUNTY
Roger A. Peatee, Bowling Green

Ohio Veterans' Bonus Provisions Are Stated

Principal provisions for payment of the Ohio bonus compensation to veterans of World War II are:

Service requirements—Service on active duty in the armed forces of the U. S. for at least 90 days between Dec. 7, 1941, and Sept. 2, 1945; and honorable discharge or separation;

Residence requirements—Veteran must have been a resident of the State of Ohio on the first day of active duty in the period specified; and must have been a resident during one year immediately preceding such first day;

Amount of compensation—\$10 for each month of domestic service during the period; \$15 for each month of foreign service; for days less than a month, one-thirtieth of monthly rate; total for any veteran not to exceed \$400.

Surviving wife or husband, children or parents of veteran who died will be paid same amount veteran would have received, except that if veteran's death was service-connected his survivors will be paid maximum amount of \$400.

Processing of the claims will be on a basis of "first come, first served", according to an announcement by Maj. Gen. Chester W. Goble, director. Forms for filing claims now are available from veterans organizations, veterans information centers, and V. A. Contact Offices. One of the primary requirements is submission of original discharge certificate, or certificate of service in lieu of lost discharge which will be stamped to preclude possible duplication.

A practicing physician for 56 years, Dr. L. W. Prichard, Ravenna, 83-year-old Portage County physician, has delivered 3,352 babies.

Proceedings of The Council

Considerable Business Transacted at Meeting Held in Columbus on Sunday, March 7; Committee Reports Received and Approved

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, March 7, 1948. Those present were: President Rutledge, President-Elect Brindley, Past-President McNamee, Treasurer Worstell; Councilors Swartz, Messenger, Bowman, Mundy, Dixon, Davis, Lincké, Swett, Micklethwaite, and Clodfelter; Dr. John A. Caldwell, Cincinnati, chairman, Judicial and Professional Relations Committee; and Secretaries Nelson, Saville, Page, and Moore.

On motion by Dr. Brindley, seconded by Dr. Messenger, and carried, the minutes of the last meeting of The Council held on December 14, 1947, were approved.

A report on membership by the Executive Secretary showed that the total membership as of March 5, 1948, was 6,600, of which 22 are military members; compared to a total membership of 7,106 on December 31, 1947.

On motion by Dr. Swartz, seconded by Dr. Bowman, and carried, the prorating of dues for new members for the third and fourth quarters of 1948 was authorized as follows: New members affiliating in the third quarter, \$10.00; new members affiliating in the fourth quarter, \$7.00.

CHANGES IN BY-LAWS APPROVED

Changes in the Constitution and By-Laws of the Toledo Academy of Medicine, recently adopted by that society, were approved by The Council on motion by Dr. Bowman, seconded by Dr. Worstell, and carried.

An amendment to the Constitution and By-Laws of the Montgomery County Medical Society, recently adopted by that society, was approved on motion by Dr. Messenger, seconded by Dr. Clodfelter, and carried.

A communication from the Hancock County Medical Society, asking The Council to approve a resolution recently adopted by that society establishing a residence requirement, was considered.

Following a discussion, on motion by Dr. Clodfelter, seconded by Dr. Brindley, and carried, the Executive Secretary was authorized to inform the Hancock County Medical Society that The Council could not approve this action in its present form, but that it would be necessary for the Hancock County Medical Society to amend its Constitution and By-Laws in the regular manner in order to accomplish the purpose of the resolution, and for the society to resub-

mit the proposition to The Council for action after amending its Constitution and By-Laws.

ANNUAL MEETING ARRANGEMENTS

A report on final plans for the 1948 Annual Meeting in Cincinnati, March 30-April 1, was given by the Executive Secretary.

Mr. Saville reported on the proposed radio coverage for the meeting, especially a walkie-talkie broadcast relative to the Scientific Exhibit by Dr. William F. Ashe, Chairman of the Committee on Scientific Exhibits. The proposed arrangements for the radio coverage were approved on motion by Dr. Bowman, seconded by Dr. Lincké, and carried.

Members of The Council discussed the question of better attendance of delegates at sessions of the House of Delegates.

Several members suggested that district meetings of delegates be held prior to the Annual Meeting. It was pointed out that a charter of a county medical society may be revoked by action of the House of Delegates for lack of representation by a delegate or alternate at three successive annual meetings of the House of Delegates.

OHIO MEDICAL INDEMNITY

A detailed report on the activities and status of Ohio Medical Indemnity, Inc., was given by the Executive Secretary showing that the present enrollment of Ohio Medical is approximately 320,000 persons. He reported also on the action taken by Ohio Medical Indemnity, Inc., with respect to retirement of all preferred shares.

LABORATORY QUESTION

A report on a meeting of the Judicial and Professional Relations Committee, held on Saturday, March 6, in the Columbus office, was presented on behalf of that committee by the Executive Secretary.

Action on a report of the committee relative to changes in the rulings and regulations governing laboratories approved for premarital and prenatal tests for syphilis was deferred, on motion by Dr. Messenger, seconded by Dr. Brindley, and carried; and in the same motion The Council recommended that a conference of representatives of the Ohio Department of Health, the Ohio Society of Clinical Pathologists, and the Ohio State Medical Association be arranged for the purpose of discussing this question and endeavoring to work out a solution.

The Judicial and Professional Relations Com-

mittee reported that it had considered a communication from the Ohio Department of Health, claiming that there appears to be an unnecessary number of sterilization operations being performed on lying-in patients in some hospitals, and that it was the opinion of the committee that no action is required inasmuch as the question can only be settled between the attending physician and the patient. On motion by Dr. McNamee, seconded by Dr. Mundy, and carried, the report and recommendation of the committee were approved.

RURAL HEALTH ACTIVITIES

Dr. Mundy presented a lengthy report on the activities of the Committee on Rural Health and presented certain recommendations made to The Council by that Committee. (See page 405.) Also, Dr. Mundy presented a report on the proceedings of the Ohio Rural Health Conference held on March 1 and 2, 1948, and of the activities of the Ohio Rural Health Council of which he is a member. On motion by Dr. Brindley, seconded by Dr. Bowman, and carried, the report and the recommendations made by the Committee on Rural Health were approved.

Following a general discussion, on motion by Dr. Brindley, seconded by Dr. Davis, and carried, The Council authorized an appropriation of \$1,000 from the funds of the Department of Public Relations as a contribution to the Ohio Rural Health Council to assist it in carrying on its activities during the ensuing year.

The Council approved representation from the Ohio State Medical Association on a special committee being organized by the Ohio Rural Health Council to make a survey of the health laws of Ohio and to recommend constructive changes, on motion by Dr. McNamee, seconded by Dr. Mundy, and carried. It was the sense of The Council that the Ohio State Medical Association should take active leadership in this project.

VETERANS ADMINISTRATION

Communications from the Cleveland Society of Neurology and Psychiatry, recommending certain changes in the fee schedule of the Ohio plan for medical care of veterans were read and discussed. On motion by Dr. McNamee, seconded by Dr. Worstell, and carried, the communications were referred to the Committee on Medical Care of Veterans for review and recommendations to The Council.

A communication from the Veterans Administration stated that the name of a member of the Association, who had been charged with irregularities by the Veterans Administration, had been restored to the list of participating physicians upon recommendation of the Ohio State Medical Association after an investigation

which revealed that the charges against the physician were without basis or justification.

NATIONAL HEALTH ASSEMBLY

The Executive Secretary presented a review of the status of bills in the Congress and called attention to the National Health Assembly to be held in Washington on May 1-4. The question of representation from the Ohio State Medical Association to the National Health Assembly was discussed but no action was taken pending receipt of further information on this matter.

On motion by Dr. McNamee, seconded by Dr. Dixon, and carried, The Council authorized the holding of district conferences of county society officers and legislative committeemen prior to the general election in November.

EMERGENCY PROGRAM

A report from the Committee on National Emergency Medical Service revealed that Dr. C. C. Sherburne, chairman of that committee, and Dr. Richard L. Meiling, a member of the committee and also secretary of the Committee on National Emergency Medical Service of the American Medical Association, and the Executive Secretary had conferred recently with Governor Herbert with respect to the formation of a State disaster committee and program, and that this and other matters would be discussed at a meeting of the committee to be held in April.

BANK RESOLUTIONS

On motion by Dr. Dixon, seconded by Dr. Lincke, and carried, the following resolution regarding a depository for the funds of the Association was adopted:

RESOLVED, That the Ohio State Medical Association open and maintain an account with the High-Town Office of the Ohio National Bank, Columbus, Ohio, for the deposit of funds received by the Association, or by the Executive Secretary of the Association, and that such funds deposited in said account shall, subject to the rules of said bank, be withdrawn from said account by means of a check, draft, order, or receipt issued in the name of the Association, signed only by the Executive Secretary of the Association, namely, Charles S. Nelson, and made payable only to the duly-elected and qualified Treasurer of the Ohio State Medical Association, and

RESOLVED, That the Ohio State Medical Association hereby guarantees to said bank the payment of all checks, drafts, and notes which may at any time be deposited without the endorsement of the Association appearing on such items and the certification of these resolutions by an officer of the Association shall bind it upon this guaranty, and

RESOLVED FURTHER, That the Executive Secretary of the Ohio State Medical Association furnish to said bank a certified copy of these resolutions and a certificate setting forth the names of the officers of the Association and a specimen of the signature of the Executive Secretary, and said bank is authorized to rely on these resolutions and such certificate as being in effect without modification until written notice of any change therein shall be delivered to it and acknowledged by said bank.

On motion by Dr. Worstell, seconded by Dr. Messenger, and carried, the following resolution regarding a depository for the funds of *The Ohio State Medical Journal* was adopted:

RESOLVED, That the Ohio State Medical Association open and maintain an account with the High-Town Office of the Ohio National Bank, Columbus, Ohio, in the name of *The Ohio State Medical Journal*, owned and published by said Association, for the deposit of funds of *The Ohio State Medical Journal*, and that such funds deposited in said

account shall, subject to the rules of said bank, be withdrawn from said account by means of a check, draft, order, or receipt issued in the name of *The Ohio State Medical Journal* and signed by any one of the following officers or employees of the Ohio State Medical Association, namely, Charles S. Nelson, business manager, or Florence Okert, assistant business manager, and

RESOLVED, That the Ohio State Medical Association hereby guarantees to said bank payment of all checks, drafts, and notes which may at any time be deposited in the account of *The Ohio State Medical Journal* without endorsement of said journal appearing on such items and the certification of these resolutions by an officer of the Association shall bind it upon this guaranty, and

RESOLVED FURTHER, That the Executive Secretary of the Ohio State Medical Association furnish to said bank a certified copy of these resolutions and a certificate setting forth the names of the officers of the Ohio State Medical Association and a specimen of the signatures of those named above as authorized to sign a check, draft, order, or receipt issued in the name of *The Ohio State Medical Journal*, and said bank is authorized to rely on these resolutions and such certificate as being in effect without modification until written notice of any change therein shall be delivered to it and acknowledged by said bank.

SPECIAL COMMITTEE AUTHORIZED

A communication from the president and secretary of the Summit County Medical Society, relative to recent action by an Akron hospital in revising its by-laws, and charging that the action taken was discriminatory against "the vast majority of physicians" in Akron and was in violation of resolutions adopted by the A.M.A. and the Ohio State Medical Association regarding membership on hospital staffs, was read and discussed. On motion by Dr. Bowman, seconded by Dr. McNamee, and carried, the President was authorized to appoint a sub-committee of The Council to investigate the question raised in the communication and similar incidences which may prevail in other parts of the State.

The Executive Secretary reported on the Ohio Hospital Construction program and called attention to an article on the matter published in the March issue of *The Ohio State Medical Journal*.

On motion by Dr. Bowman, seconded by Dr. Worstell, and carried, payment of 1948 dues amounting to \$50 for the Association to the Conference of Presidents and other officers of state medical associations was authorized.

A communication from the Ohio Department of Health, stating that a regional conference would be held at the Spring Mill Hotel, Mitchell, Indiana, April 21 and 22, at which the question of mobilizing public support for complete coverage of areas with local full-time health units would be discussed, was considered. On motion by Dr. Davis, seconded by Dr. Lincke, and carried, Dr. Brindley was authorized to attend this conference as the official representative of the Ohio State Medical Association.

A suggestion that the State Association sponsor a conference of office secretaries of physicians for the purpose of providing them with information about forms and procedures which a physician must fill out and file was considered. On motion by Dr. Clodfelter, seconded by Dr. Lincke, and carried, The Council authorized the Columbus office to explore the possibilities of such a conference and report back to The Council.

On motion by Dr. Davis, seconded by Dr. Clodfelter, and carried, a recommendation of the Woman's Auxiliary Advisory Committee that the Association contribute \$250 to the Auxiliary to assist in expenses in connection with publication of the *Auxiliary Bulletin* this year, was approved.

There being no further business, The Council adjourned to meet on Monday evening, March 29, at the Netherland Plaza, Cincinnati.

Attest: CHARLES S. NELSON,
Executive Secretary.

Details of Annual Meeting To Appear in May Issue

A complete report of various activities and proceedings at the Annual Meeting of the Ohio State Medical Association in Cincinnati, March 30, 31, and April 1, will appear in the May issue of *The Journal*. Reports will include the address of the President; proceedings of the House of Delegates; proceedings of The Council; newly elected officers; total registration by name and location; report of the Annual Meeting of the Woman's Auxiliary; as well as highlights and interesting side-lights of the meeting.

American Public Health Association To Meet in November

The 76th Annual Meeting of the American Public Health Association will be held in Boston, Mass., Nov. 8-12. An attendance of 4,000 is anticipated.

Among related organizations which will hold their annual meetings with the Association are the following: American School Health Association, Association of Maternal and Child Health and Crippled Children's Directors, Association of Reserve Officers of the U.S. Public Health Service, Association of State and Territorial Health Officers, Conference of Municipal Public Health Engineers, Conference of Professors of Preventive Medicine, Conference of State and Provincial Public Health Laboratory Directors, Conference of State Directors of Health Education, Council of State Directors of Public Health Nursing, National Committee of Health Council Executives, and Public Health Cancer Association.

Dr. Reginald M. Atwater is the Association's executive secretary with offices at 1790 Broadway, New York 19.

Veterans Administration Announces New Rules To Expedite Fee-Basis Payments

CHANGES in Veterans Administration procedures which will expedite fee-basis payments and enable the Veterans Administration to fully utilize all funds available for fee-basis authorizations have been announced. In a letter to the Ohio State Medical Association, enclosing a release on the subject, Dr. Peter A. Volpe, branch medical director for the V. A., explains the reasons for these changes.

Following is his letter in part:

"To provide the best possible service to veterans under the Veterans Administration out-patient medical program it has been found necessary to make certain changes in authorization and accounting procedures. As you know, we have a limited amount of money available for use in authorizing fee-basis treatments and it has become increasingly important that we utilize these funds in a way to obtain maximum benefits to eligible veterans.

"Some of the changes that are being made will have a direct effect on physicians participating in the Ohio State Medical Association-Veterans Administration "home-town" treatment plan, but we want to assure you that all departures from the old procedures have been made in the best interest of the program as a whole. We are constantly endeavoring to give better service to veterans and improve our handling of accounts with participating fee-basis physicians.

SPEEDIER PROCESSING

"Many physicians in the past have been dissatisfied because of delays in receiving payments from the Veterans Administration. We believe this situation is much improved and are confident that under our new system, and with the necessary cooperation of all participating physicians, future payments will be processed promptly.

"One of our major problems in making full use of available funds has been that in many cases we have not been billed by physicians for authorized treatments. This has meant that about 20 per cent of our available funds have been encumbered or frozen for treatment that apparently has not been given. Nevertheless, the money has been set aside and cannot be used until our liability is definitely established. Our new procedures, briefly, are designed to make the fullest pos-

sible use of our funds and to release these frozen amounts for immediate use where needed."

NEW INSTRUCTIONS

The information sheet announcing the future procedure to be followed is given below:

1. In the future, all authorizations to fee-basis physicians will contain the following instructions:

"If the veteran fails to report, or if service is not furnished during the authorized period, the issuing office must be notified to that effect, and all papers returned. If neither the invoice nor the notification referred to above is received by the issuing offices within 30 days after the expiration of the authorization, the authorization will be cancelled automatically. An invoice received after authorization is cancelled will be held pending availability of funds required to re-establish the authorization."

2. The period of authorization for out-patient medical treatment will be for 30 days, and the termination of the authorization will be calculated from the date of issuance of the authorization rather than the first of the month. Reports of treatment will no longer be required by the twenty-third of the month but must be received with all requests for continuing treatment and/or invoices.

30-DAY PERIOD

3. Periods of authorization for pension examinations will be restricted to 30 days from date of authorization. If the examination which has been authorized has not been accomplished within the authorized 30-day period, return all papers and inform the issuing office with a note why the examination could not be accomplished. If additional time is necessary, inform the issuing office by letter in sufficient time to preclude automatic cancellation.

4. Follow instructions given in authorization or letter. If unusual conditions develop inform issuing office of these details and request further instructions.

5. If additional tests or X-rays are found necessary, confer with authorizing V.A. office before proceeding with these tests or X-rays. Get authority before proceeding with additional service.

6. Submit bills or invoices promptly; this will expedite payments.

Proportion of Doctors on National Health Assembly Committee for Washington Meet Is Increased; Names of Participants Still in Doubt

THE purpose of a National Health Assembly to be held in Washington from May 1 to 4 will be to enlist the aid of all major health agencies and organizations in formulating the first steps toward national health goals for the next 10 years, according to an announcement from Federal Security Administrator Oscar R. Ewing.

Since announcing the original 24-person Executive Committee for the Assembly, which included the name of only one physician, Mr. Ewing, before this article was written, had appointed an additional 12 persons among whom are three more physicians engaged in activities of organized medicine.

The Assembly was called by Mr. Ewing to advise him on the health program requested by President Truman. "One important thing that we hope will come out of the Assembly is a clearer picture of just how much agreement there is in certain supposedly controversial health fields," Mr. Ewing said in his announcement directed to the medical profession. "I have an idea we are going to find out that these areas of agreement are larger than many people think. Once we have that established, we can find out how far we can all go forward on a nationwide front."

PANEL DISCUSSIONS

Seven or eight hundred delegates are expected to attend the meeting. According to the announcement, specific health problems will be explored in panel discussions covering professional personnel, hospital facilities, local health units, chronic disease, maternal and child health, rural health, research, medical care, community planning, rehabilitation, dental health, mental health, accidents, and nutrition. Emphasis will be placed on local situations and community action. Members of the 14 panels will represent private and public, national, state, and local organizations concerned directly with these problems. The membership of the panels has not been announced by Mr. Ewing.

HOPE TO FORM BASE FOR ACTION

Findings and recommendations of these panels, Mr. Ewing said, should form a base for the ten-year national progress guide requested by the President. He added that more immediate benefits from the Assembly are expected to be:

1. A guide to community action for local health improvements;
2. A practical pattern for cooperation among

all organizations in the health field—public and private, national, state, and local; and

3. A better knowledge of our present health picture and the most urgent needs for improvement.

WHO WILL BE INVITED?

It was not known as this issue went to press just which organizations and agencies will be invited to take part in the assembly officially.

Neither the Ohio State Medical Association nor the Ohio Department of Health has been requested to send representatives, although both organizations will do so if requested.

A.M.A. SUSPICIOUS

The Journal of the A.M.A. in its March 6 issue charged that the 1948 assembly had the earmarks of being political and propagandistic, a situation similar to a conference held in 1938 when the meeting was stacked with representatives of agencies and groups favoring compulsory sickness insurance.

"The medical profession, having participated in the conference of 1938, which was in no sense of the word a conference, cannot be condemned if it views with reluctance a call for a similar assembly, particularly in an election year and particularly just before the major political parties will be drafting the platforms on which they propose to seek public support," *The Journal of the A.M.A.* observed. "No doubt an assembly of qualified leaders in the field of health and medicine and research could assemble around a table or even in a small hall and by free interchange of information, experience, and opinion develop a program for the nation's health which would lead to intensified activity and progress during the next ten years.

"Whether or not seven hundred persons can get together in a dozen or more panels and work out similar advancement is, of course, questionable. Granting that panels of thirty or forty persons can discuss the problems that will be put before them each day, the medical profession will still be concerned as to the ultimate fate of recommendations that may come from these panels.

"If they are to be submitted to the executive committee already set forth and if that committee is to have final decision as to the recommendations that are to be announced to the public, the objectives of the medical profession are defeated before the assembly has been held.

"In most such assemblies the opening speeches are given vast circulation throughout the nation over the radio and in the press. If the opening addresses are made by President Truman and Mr. Ewing, the medical profession already knows that they will be another endorsement of nationalized medical care and compulsory sickness insurance. What arrangements will be made for addresses by those opposed to such a pro-

gram, and what opportunity will they have for reaching the public that would be reached by the other addresses? Is the new National Health Assembly to be simply another sounding board for a leftist medical program?

"These are questions that should be answered for the medical profession now! The implications involved in such an assembly are so serious for the medical profession that it should be called into early conference on the development of the program, the publicity, and the ultimate use of the material developed by the conference if full participation by the medical profession is requested. The Board of Trustees of the American Medical Association at its recent meeting in Chicago reached this conclusion, and the authorities for the National Health Assembly have been informed of their opinion."

MEMBERS OF COMMITTEE

The 12 members added to the original 24 persons named on the Executive Committee are: Dr. Edward I. Bortz, president, American Medical Association; Dr. Paul R. Hawley, chief executive officer, Blue Cross Hospital Service and Blue Shield Medical-Surgical Service as of April 1; Dr. R. L. Sensenich, president-elect of American Medical Association; Graham L. Davis, president, American Hospital Association; Dr. Robert P. Fischelis, secretary, American Pharmaceutical Association; Dr. Vlado A. Getting, M. D., president of Association of State and Territorial Health Officers; Dr. Harold Hillenbrand, general secretary, American Dental Association; William Harding Jackson, chairman, Hospital Council of Greater New York; Dr. James L. Morrill, president, University of Michigan; James G. Patton, president; National Farmers Association; and Hon. Jerry Voorhis, general secretary, Cooperative League of the U. S. A.

ORIGINAL APPOINTEES

The initial 24 members named are the following: Dr. George F. Lull, secretary and general manager, American Medical Association; Barry Bingham, editor and president, *Louisville Courier-Journal*; Mrs. J. L. Blair Buck, president, General Federation of Women's Clubs; Earl Bunting, president, National Association of Manufacturers; Miss Elisabeth Christman, secretary-treasurer, National Women's Trade Union League.

Dr. Louis I. Dublin, second vice-president, Metropolitan Life Insurance Co.; Judge Jerome N. Frank, U. S. Circuit Court of Appeals, New York; Albert S. Goss, president, National Grange; William Green, president, American Federation of Labor; The Most Rev. Francis J. Haas, Bishop of Grand Rapids, Mich.; Miss Frieda Hennock, New York City; Mrs. L. W. Hughes, president, National Congress of Parents and Teachers.

Eric Johnston, president, Motion Picture Producers and Distributors of America; Allan Kline, president, American Farm Bureau Federation; Mrs. Mary Lasker, New York City; Mrs. David

Levy, New York City; Mrs. Eugene Meyer, Washington, D.C.; Philip Murray, president, Congress of Industrial Organization; Mrs. Anna M. Rosenberg, New York City.

Earl O. Shreve, president, Chamber of Commerce of the U. S. A.; Dr. Frank Stanton, president, Columbia Broadcasting System, Inc.; M. W. Thatcher, president, National Federation of Grain Cooperatives; Walter White, secretary, National Association for the Advancement of Colored People; and Dr. Abel Wolman, chairman, executive board, American Public Health Association.

O.S.M.A. Committee on School Health Named by President

A Committee on School Health, authorized by The Council at the December 14 meeting, recently was appointed by Dr. R. L. Rutledge, president of the Ohio State Medical Association.

The new committee consists of the following: Dr. Carl A. Wilzbach, Cincinnati Board of Health, chairman; Dr. Thomas E. Shaffer, Ohio State University College of Medicine; Dr. J. W. Wilce, director, University Health Service, O. S. U.; Dr. C. W. Wyckoff, Cleveland; Dr. Charles T. Atkinson, Middletown; Dr. L. A. Hamilton, Athens; Dr. T. L. Light, Dayton; Dr. R. E. Shell, Van Wert; Dr. John F. Miller, Newark; Dr. Margaret O'Neal, Zanesville; Dr. F. A. Halloran, Springfield; Dr. H. B. Thomas, Gallipolis; Dr. Russell C. Bane, Chillicothe; and Dr. J. M. Painter, Kent.

The purpose of the committee is to promote closer coordination between the medical profession and school officials administering programs of health and medical services and health educational activities in universities, colleges, and secondary school systems in the State, and to lead in developing policies and procedures for such programs.

The Council further requested that each county medical society establish a local committee on school health. A bulletin on this phase will be sent to all County Society secretaries in the near future.

Programs of Proctologists

Members of county societies are invited to attend meetings of The Cincinnati Proctologic Society, which includes members in Ohio, Indiana, and Kentucky. The remaining two meetings of the season are scheduled in Hotel Gibson as follows:

April 9 at 6:15 p. m., "Case Reports of Epidermoid Carcinoma of the Anus and Colostomy in Lymphopathia Venerea", by Dr. A. G. Carmel; and May 14 at 6:15 p. m., "Drug Sensitivity in Proctology", by Dr. Arthur Wells.

Reservations may be made with Dr. Stewart R. Jones, secy., 801 Carew Tower, Cincinnati 2.

Health Department Includes Central Registry and County Aid in Cancer Program Plans

THE Cancer Control Program of the Ohio Department of Health has developed to a point where a number of field workers besides personnel in the central office are devoting full time to combat the disease. Twenty-one nurses and five other persons in clerical and technical capacities throughout the State are now being paid full-time salaries out of the Federal grant-in-aid appropriation, according to Dr. Walter B. Lacock, chief of the Cancer Division. Also a limited amount of equipment has been purchased for use in cancer control.

A budget has been developed for the central office for funds coming from the Federal grant-in-aid which amounted to \$112,000 for the fiscal year 1947-48. A comparable amount is available for the next fiscal year, and it is contemplated that Congress will make provision for subsequent annual appropriations.

SURVEY USED AS BASE

Although the cancer control program of the Department is still in the formative stage, the preliminary survey of cancer prevalence and of available cancer control facilities has given the Division of Cancer a foundation upon which to work.

The survey was conducted by Dr. Lewis C. Robbins, of the U. S. Public Health Service, at the joint request of the Cancer Committee of the Ohio State Medical Association and the Ohio Department of Health. An initial grant by the Federal Government provided funds for the survey, a report of which is now available.

MAJOR OBJECTIVES

A major objective of the Division is establishment of a State central registry to which may be reported all cases of cancer discovered in the State, with such information as age of incidence, type of cancer, and results of therapy.

Under support of local cancer control programs are planned such items as provision of additional public health nurses for case findings in cancer, and the follow-up of suspicious cases found in detection centers; provision of some items of clinical equipment for detection centers; provision of funds for nominal fees to clinicians and clerical personnel for registries which contribute their services to detection centers.

HOW FUNDS CAN BE USED

Federal grant-in-aid funds may be used for provision of personnel to cancer clinics, for development of such administrative organizations that may be required in the Department to provide for the training of personnel in the field of

This is the second in a series of articles on the organization, functions, and program of the Ohio Department of Health and its subdivisions. The first of the series, on the recent reorganization of the Department under Dr. John D. Porterfield, director, appeared in the March issue.

cancer, or for meeting any needs with the exception of the actual provision of hospital services and medical care.

Allotments to local health departments will be made in the form of cooperative budgets in which grant-in-aid funds allotted will be matched against funds or services provided by the local health department, the local medical society, and the local unit of the cancer society. It will be required that all three of these agencies have developed a cooperative program in order that this support may be obtained.

MUST BE FULL-TIME UNITS

It also will be required that local health departments be full-time units in order to participate in this allotment. No cooperative budgets can be developed by the Ohio Department of Health with any other agency than a full-time local health unit. Fifty-six of Ohio's 88 counties and 53 cities in the State now have full-time health administration, according to records in the Division.

SURVEY DATA

The survey brought out some interesting facts about cancer in the State. The cancer mortality rate in Ohio is somewhat higher than that for the country as a whole, because Ohio has a population in the higher age group. The reported death rate from cancer has increased more or less steadily since 1909. The mortality rate in 1909 was approximately 75 per 100,000 population.

In 1945, cancer caused the deaths of 10,168 persons in Ohio, giving a cancer death rate of 144.3 per 100,000 population. The age factor in cancer is of greatest importance. The age group over 45 years, representing 36.5 per cent of Ohio's population, accounts for 95 per cent of cancer deaths. There are an estimated 8,000 cases of undiagnosed cancer in the State at present. The "lay-delay" period—that period of time from onset of the first symptom until the patient sees a physician—is estimated at six months.

CLINICS CHECKED

In a survey of 20 clinics, as of March, 1947, not including cancer detection centers, it was

found that 11 were approved for diagnosis and treatment by the American College of Surgeons; one was approved for diagnosis only; one was approved as a departmental clinic; and seven were not approved. Information compiled since shows that additional clinics or departments have been added to the approved list. In addition to clinics surveyed, there are perhaps between 15 and 20 detection centers in the State.

Six of the 20 clinics surveyed were accepting only persons referred by physicians. The time of the cancer clinics staff can be used most effectively if referrals are by physicians only, the report indicated. The percentage of cancer found among cancer clinic patients when referral is by physicians runs usually from 25 to 50 per cent. When referral is by agencies and initiative of patients, the percentage may fall as low as 0.5 per cent. Eight of the 20 clinics were referring patients back to physicians following diagnoses.

SOME RECOMMENDATIONS

In his survey report, Dr. Robbins made a number of suggestions for study and discussion gleaned from experiences of other state medical societies, health departments and agencies. Some of them are as follows:

Statistics—Selection from the cancer case registry for follow-up by public health nurses or social workers of all lapsing cancer cases. The publication of statistics concerning five-year cures in *The Ohio State Medical Journal* following one year operation of the central cancer registry.

Pathology—The provision of free laboratory tissue service for the medically indigent, to stimulate more frequent biopsies, either by (a) subsidy of the private pathologist, (b) free tissue examination by the private pathologist, or (c) the employment of a state pathologist on full or part-time basis. The employment of a pathologist trained in the Papanicolaou strain to educate private physicians and cancer clinics in its use and to supervise examination of Papanicolaou strains in a laboratory. The employment of a technician trained in the Papanicolaou strain to screen suspicious slides for later examination by a pathologist.

Lay Education—The establishment of a speakers bureau of physicians for lay education. The use of abstract clerks or other personnel to assist, under trained health educator, in the organization of lay groups for instruction by physicians from the speakers bureau. Development of cancer registry statistics as teaching material for physicians and medical students.

COURSES FOR PHYSICIANS

Physicians' Education—Initiation of short and long courses for physicians in diagnosis and treatment of cancer and of "Cancer Teaching Days" in county medical societies, an honorarium and expenses to be paid experts for the time

spent. The establishment of fellowships for physicians in radiology, pathology, and other specialties relating to cancer, and of fellowships for pathologists and technicians in the use of the Papanicolaou strain. The institution of a program of education for the dental profession on cancer of the mouth and lips. The creation of a monthly bulletin to physicians with abstracts of value to them on the diagnosis and treatment of cancer.

Cancer Clinics—Promotion of more cancer diagnosis and treatment of clinics to be set up according to standards outlined by the American College of Surgeons. The development of an Ohio Association of Cancer Clinics similar to that developed in Connecticut which organized educational programs for physicians and worked out many forms for mutual use. Provision for a consultant for cancer clinics to assist in problems of diagnosis and treatment, such as Massachusetts has. Allocation to clinics of funds for (a) salaries of secretaries and follow-up personnel, (b) salaries of physicians in training in cancer clinics, and (c) supplementing diagnostic and treatment facilities.

Hospitalization—State subsidy of cancer cases for hospitalization. The building of a state cancer hospital in connection with a medical school for teaching purposes.

COMING MEETINGS

American Medical Association Annual Meeting, Chicago, June 21-25.

American Association for the Study of Goiter, Toronto, Canada, May 6-8.

American Urological Association, Boston, May 17-20.

Mahoning County Medical Society, 19th Annual Postgraduate Assembly, Youngstown, April 14.

National Health Assembly, Washington, D. C., May 1-4.

National Society for the Prevention of Blindness, 1948 Conference, Hotel Radisson, Minneapolis, Minn., April 5-7.

Northern Tri-State Medical Association Findlay, April 13.

Postgraduate Institute

The 12th Annual Postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, Philadelphia, Pa., April 20-23. A copy of the preliminary program and any further information may be secured from Gilson Colby Engel, M. D., director, 301 S. 21st St., Philadelphia 3, Pa.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

CHECKING UP ON WASHINGTON

Brookings Institution, a private survey and research agency, rapped compulsory health insurance in a special report prepared for the subcommittee of the U. S. Senate Committee on Labor and Welfare which has been hearing health and medical proposals . . . another nail in the coffin of radical medical measures now pending in Congress, observers believe.

A two-day hearing held on S. 1290, national school health services bill, backed by National P-T-A . . . opposed by A.M.A. on grounds it provides for treatment (little Wagner-Murray-Dingell Bill) and would centralize control in Washington. *Washington Report on the Medical Sciences* reports that certain amendments offered by the Federal Security Agency, proposing a grab for more power by that agency and making the bill more "education" than "health," threw a monkey wrench into the machinery . . . making favorable action doubtful. A letter to Taft and Bricker warning them that this may be another case of the camel putting his nose under the tent would be in order.

Hearings on S. 545 (Taft Bill) and S. 1320 (Wagner-Murray Bill) will be resumed but indications of a complete collapse of interest in either at this time are apparent.

It is reported that Drs. Lull, Henderson, and Sensenich, A.M.A. officials, conferred, recently with President Truman . . . at White House request. Why? No one knows as yet. Perhaps to iron out differences over the National Health Assembly, called by Administration for May 1-4, which A.M.A. charges will be rigged in favor of proponents of radical medical programs unless real pressure is exerted . . . Ohio note: Reported that Joseph W. Fichter, Master of the Ohio State Grange, has been invited to serve as chairman of the Assembly's panel on rural health.

Kiplinger Washington Letter predicts that Social Security changes this year will be minor and that Congress will delay action on national health program until next year . . . not indicating what is meant by "action."

House Appropriations Committee has deferred allocating money for assistance to states under Mental Hygiene Act until investigation to find out if funds in past have been devoted "to the most essential and worth-while objectives in this field."

Same committee has authorized appropriation of \$60,000,000, and an additional amount of \$75,-

000,000 for contractual obligations, for local hospital construction under the Hill-Burton act.

The much talked-about measure to provide more Federal aid for local public health departments has been introduced by Senator Saltonstall, Mass., namely, S. 2189 . . . with backing of State and Territorial Health Officers and P-T-A. . . . In order to participate, the states would have to submit a plan to the Surgeon General, U. S. Public Health Service for approval . . . He would determine the amount of the subsidy to each state and would prescribe regulations with which the states would have to comply . . . If this is enacted the states again will have this question squarely before them for answering: Do we want to accept more Federal aid and the regulations which go with it, or can we, and are we willing to finance our own health programs?

WHY BE AFRAID OF THE BIG BAD WOLF! LET'S GET IN AND PITCH

Elsewhere in this issue will be found an article regarding the National Health Assembly to be held in Washington, May 1-4, under the sponsorship of the Federal Security Agency at the request of President Truman.

In an editorial published in *The Journal of the A.M.A.*, issue of March 6, it is stated that the forthcoming meeting "bears all the stigmas—political and propagandistic—that accompanied the National Health Assembly of 1938".

Maybe that is so. Perhaps those who called the conference had in mind that this is an election year; perhaps they plan to use the conference as a sounding board for compulsory health insurance.

Nevertheless, in our opinion, the A.M.A. editorial was a bit premature and poorly-timed. It seems as if the A.M.A. played right into the hands of Security Administrator Oscar R. Ewing who was quick to issue a statement that he could not believe that the medical profession, even though it is opposed to compulsory health insurance, would refuse to sit down with others to discuss health questions about which there can be little or no disagreement.

Speaking frankly, it is our opinion that the best attack which the medical profession can make is to get in and pitch. In other words, it should make every possible effort to see that a large number of well-informed representatives of the A.M.A. and state medical societies are in attendance. These men should take an active part in the discussions. Everything possible should be done to see that the medical

profession's views are presented, heard, incorporated into the records, and given ample publicity.

The Council of the Ohio State Medical Association has authorized the sending of representatives from Ohio to the conference. If other state medical societies will do so, those representatives, together with those of the A.M.A., may be able to make the 1948 conference something different than the one of 10 years ago.

The day when you can meet things head-on merely by sitting back and crabbing is gone. Today is a time of action. The gravest error which the medical profession can commit is to let matters go by default. Certainly it would be far better to lose after putting up a real fight in the National Health Assembly, or elsewhere, than to lose without making any attempt to guide the thinking and actions of the conference.

In the final analysis, the National Health Conference is going to be held, with or without participation on the part of the medical profession. Surely the medical profession would have everything to win and nothing to lose by rolling up its sleeves and getting into the free-for-all which is scheduled to take place on May 1-4.

ARE NEW V. A. HOSPITALS REALLY NEEDED?

Just to keep our readers informed on trends, we offer the following data from a statistical summary of the activities of the Veterans Administration for the month of December, 1947:

Veterans awaiting hospital admission as of December 31: 17,556, of which 16,827 had non-service-connected disabilities.

V. A. patients in hospitals as of December 16: 106,179, of which 68,825 had non-service-connected disabilities.

Moreover, it may be noted that plans and specifications for building dozens of additional V. A. hospitals are in the mill.

Just what will be done, if anything, to take the V. A. out of the business of supplying medical and hospital services to all veterans, regardless of their service-connected status, is anybody's guess. Nothing, perhaps, until the veterans themselves begin to realize that it is their money which is being used by Uncle Sam for this purpose; that the dollars which they pay in taxes shrink in value after the Federal Government takes its cut for bureau administration; and that government medical-hospital care programs can't be run as economically as under non-governmental management.

It's a delicate subject with the politicians, we realize. Nevertheless, it might be something you would like to discuss with your Congressman the next time you see or write him.

RIGHT KIND OF HEALTH DEPARTMENT REPORT

Annual report of the health department of Sandusky and Erie County crossed our desk recently. Dr. F. E. Mahla, the health commissioner, deserves congratulations for the make-up and content of the report.

Differing from so many reports of this kind, Dr. Mahla's document contains specific recommendations to city and county officials on how the services of the department can be improved. Also, it reviews in readable fashion the accomplishments of the department during the past year.

This report is not just a series of figures and charts. It tells what the department has been doing and hopes to accomplish. It should lend itself to good newspaper stories—good publicity—good health education. It tells the people what they are getting; where and how to get the services provided.

As we have said before, too many times health department reports do not tell much about the good things in the health situation of the community but confine themselves to a lot of dry statistics in which deaths and sickness stand out like a sore thumb. The brighter side should be painted when the facts justify.

HOW ABOUT A "HEALTH DAY" IN YOUR COMMUNITY?

This month's medal of achievement should go to the Woman's Auxiliary of the Summit County Medical Society for having sponsored a most successful "Health Day" in Akron, the feature of which was a public exhibit of material on medical and health subjects.

More auxiliaries and medical societies should back this plan of acquainting the people of their respective communities with authentic information on health and what the medical profession and health agencies of the community have to offer in the way of services and facilities.

Naturally, this is the finest kind of public relations—something which the auxiliary and medical society, big or small, can do. The Public Relations Department of the State Association can, and will, cooperate and assist, as it did in the Akron project.

RURAL HEALTH AND THE LOCAL MEDICAL SOCIETY

Recently a Community Forum on Rural Health was held in Highland County under the auspices of various farm organizations.

Representatives of the Highland County Medical Society took an active part in the program and conferences. Reports on the meeting indicate that the lay and medical groups cooperated beautifully; that the assistance of the medi-

cal profession was deeply appreciated: and that everyone, including the physicians, got real benefits from the discussions.

That, in our opinion, is good public relations. It would suit us fine if we could publish a statement like this regarding every county in Ohio.

Those who had the opportunity to attend the Ohio Rural Health Conference in Columbus on March 1 and 2 can testify to the fact that real cooperation between the medical profession and farm groups is taking place. The field is a big one. Each group needs the advice and assistance of the other.

If this can be accomplished between the state groups, it can be accomplished at the grass roots.

The conference in Highland County and those which have been held in other areas, indicate that a great opportunity awaits the county medical society.

SUMMER ROUNDUPS SHOULD HAVE YOUR SUPPORT

The Summer Roundup Program, or health check-up project sponsored by Parent-Teacher Associations for children entering school for the first time, is just around the corner.

To repeat what has been said again and again in these columns, the P-T-A groups should have the wholehearted support and active participation of the physicians of Ohio in this program. They do in most communities. See to it that they get your cooperation and that of other physicians in your town.

Obviously, the smart thing for each county medical society to do would be to offer its help to the P-T-A. If that is not feasible, then it is up to individual physicians to cooperate.

What is to be gained by haggling over details, as has been the case in a few areas? It's a worth-while program, isn't it? The work has to be done by physicians—competent ones—doesn't it? The medical profession believes that youngsters should receive frequent health checkups, doesn't it? If the P-T-A can influence parents to have this done for their children, it deserves commendation and help, doesn't it?

When the P-T-A of your community gets ready to go with this constructive community project, offer your assistance. You can't afford to be a nonparticipant.

WHAT'S BEHIND EXIT OF DR. PARRAN?

Apparently there was more to the failure of President Truman to reappoint Dr. Thomas Parran as head of the U. S. Public Health Service than just a routine switch of personnel.

Raymond Moley in his newspaper column states that Parran was caught in the crossfire of shots fired by the proponents and opponents of com-

pulsory health insurance measures. Another commentator indicated that Federal Security Administrator Oscar Ewing wanted more authority over the U.S.P.H.S. than was possible with Parran in the saddle.

Moley commented: ". . . the best guess is that the President in an election year can hardly afford a fight with senators who oppose Dr. Parran on the government medicine issue. Still, the President will suffer the wrath of those who feel that this is another Roosevelt man overboard."

More evidence, in our opinion, that health and politics won't mix, and that it shouldn't be tried.

PROBLEM OF NIGHT CALLS NEEDS IMMEDIATE ATTENTION

How to meet the problem of night calls in the most satisfactory manner always has plagued the individual physician, and physicians as a whole, in almost every community.

Correspondence received at the Columbus Office of the State Association and newspaper clippings indicate that the problem is not being licked. Complaints that persons who have called physicians late at night have been unable to secure the services of their own physician, or indeed, any physician, are increasing. Few problems in the field of medical service are arousing so much public discussion and criticism at the moment.

Whether the resentment which is arising against the medical profession because of this is justified or not, the medical profession is being harmed by the situation, and it must do something to meet the problem.

Although a physician legally is free to choose whom he will serve, ethically and morally, he is obligated to respond to any emergency call and, as the Principles of Ethics state, "whenever temperate public opinion expects the service." The physician who is imbued with the real traditions and humanitarian principles of medicine knows how to interpret these questions, and he leans over backward in trying to fulfill his obligations to the public.

Nevertheless, in these days of heavy demand on available medical personnel, even physicians who are trying to give unselfish service to the public are finding themselves hard pressed to respond to all necessary calls.

In our opinion, each county medical society in Ohio should put this question on its docket for discussion at its next meeting. Some organized attack on the problem must be made. Here are a few suggestions which might be considered:

1. Issue a statement to the public, for publication in the press and on the radio, urging people

to confine their calls late at night to real emergencies.

2. If the society has an organized telephone exchange, work out arrangements for night calls on a rotating basis, and advise the public of this plan.

3. If no telephone exchange is maintained, explore the possibilities of establishing one, perhaps through the local hospital, or hospitals, as a beginning, and advise the public accordingly.

4. If no plan can be worked out for a telephone exchange, endeavor to get all physicians of the community to cooperate in working out a night-call schedule, on a rotating basis, and publicize this schedule as has been done in some areas regarding "day-off" schedules.

5. Use every possible means to impress on county society members the importance of meeting this problem in order to eliminate justifiable complaints and to strengthen patient-physician relationships.

"I AMOUNT TO SOMETHING; I'M WORTH WHILE"

To the boys and girls now in medical school and to recent graduates, we recommend careful reading of the following separate, but not wholly unrelated observations:

Writing in *The Cleveland Press*, Carlton K. Matson spins an interesting human-interest story about the general practitioner in a small community in Northeastern Ohio who doctored his mother. He closes his story with the following soliloquy:

"Most humans have doubt at sundown on many a day as to whether anything has been accomplished by them to advance the cause of mankind, or make this a better world. You've sold some groceries, written some editorials, sawed some wood, cooked some meals, written a few pages of a book or milked some cows.

"Maybe you've done your best. But it's a long way from the hopper to the grist, and when the shades of evening fall the average tired soul will inescapably turn on himself with 'So what?'

"But a doctor who has gone into lonely and discouraged homes, where there was fear for the sick, and no one else at hand to administer remedy and give hope, can really say, 'I amount to something. I'm worth while.' "

In a recent issue of *The Detroit Medical News*, Dr. Ralph A. Johnson offers this timely contribution:

"It is obvious to every practicing physician that despite the wonderful advances in science, skill, and knowledge that Medicine has made, and is still making, there yet remains a basic need for Art. What is this Art? It is judgment, psychology, salesmanship, and a sixth sense born of intuition and experience. This Art is that something that makes a patient feel better and safer, now that his doctor is present. Certainly the Art of Medicine is warm, personal, individual, and intangible. Medical Science is cold, impersonal and exact. The proper blend-

ing of these two makes a man an adequate and well-balanced doctor. Most financially successful physicians are long on Art and short on Science; but the best doctors are strong on both qualities. Art cannot be taught, it must be acquired by experience on the front line of practice. It cannot be given, it must be earned. It can be abused and misused, but happily the instances are few. It can be ignored, and unhappily the instances are many."

In our opinion, these observations, one by a layman, one by a physician, contain some mighty fine advice for the about-to-be-physician—also many now in practice.

They have tried to get across to the student and young physician the points that the human side of the practice of medicine is what has made medicine great; that the doctor who is "worth while" is the one who wins the confidence, respect, and love of his patients; that the use of gadgets, laboratories, and equipment, important as they may be in the practice of modern medicine, cannot take the place of judgment, experience, personality, and character; that the know-how in medicine is not going to be learned through research, lectures, and acquiring of more and more certificates and diplomas but only through actual experience and contact with patients—human beings, not mice, test tubes, charts, and case histories.

Maybe we're wrong but it seems to us as if medicine is becoming more and more a victim of the machine age, and that the sooner educators, students, and many physicians in private practice realize this, and take steps to re-establish human relationships in the practice of medicine, the better off everyone, including the medical profession, will be.

ADS ON ANTIVIVISECTION SHOULD BE SQUELCHED

While editorializing about the need for expansion of scientific research programs, costing millions of dollars, some newspapers in Ohio continue to accept advertising from the National Antivivisection Society.

This looks as if the editorial department and business office of these newspapers should get together and decide whether the paper is for or against scientific progress.

To the informed person it is quite obvious that much scientific research cannot be carried on without animal experimentation, and that without continued animal experimentation, mankind will suffer.

There should be no misunderstanding among newspaper editors and owners about this. Talk it over with your local editors. Set them straight if necessary. It would seem apparent that no newspaper would be of disservice to the public intentionally.

Report on Rural Health Activities Made to The Council; Survey of Interns, Residents, and Students on Where They Plan To Practice and Why Is Analyzed

AN extensive report on the activities of the Committee on Rural Health of the Ohio State Medical Association, those of the Ohio Rural Health Council on which the Association is represented, and various conferences on this subject which have been held throughout the State during recent months, was presented to The Council at its meeting on March 7 by Dr. Carll S. Mundy, Toledo, chairman of the committee.

Dr. Mundy called attention to the Ohio Rural Health Conference held in Columbus on March 1 and 2 in which representatives of the Ohio State Medical Association took a prominent part, and to similar district conferences held in Wilmington and in Highland County in which members of the medical profession participated. He stressed the importance of active cooperation and participation by physicians in the programs, and efforts of rural groups and residents, designed to bring about better health services in their communities.

WHAT CAN BE DONE LOCALLY

A review of the Columbiana County Health Survey, made by volunteers from among the farm folk of that county, was presented and the work done there commended, it being cited as a typical example of what can be done by voluntary agencies and persons of a community to try to work out their own problems.

Chairman Mundy reviewed for The Council the actions taken and recommendations made by the Committee on Rural Health at a recent meeting, and the report was approved by The Council.

Following is an outline of the committee's deliberations in which Mr. Sewall Milliken, extension specialist in rural health organization, Agriculture Extension Department, Ohio State University, participated:

SCHOOL HEALTH WORK IMPORTANT

The committee discussed briefly the proposed Committee on School Health, and emphasized the importance of county medical society committees on school health in rural areas.

A report on the District Rural Health Conference, held December 5 at Wilmington, and concerning which an article appeared on page 80 of the January issue of *The Journal*, was presented by the Executive Secretary.

The committee reaffirmed its previous recommendation to The Council, asking the appointment of rural health committees in all county

medical societies, and suggested that similar committees be established in the county woman's auxiliaries.

CAN THEY MEET COMPETITION?

The ability of graduates of rural high schools to meet competition in premedical and medical schools was discussed, and it was requested that Mr. Milliken make a study to determine what percentage of students from the rural high schools meet with difficulty in college and medical school, especially in the sciences necessary in medical training.

Mr. Milliken reported on activities involved in the organizing of county health councils, and agreed to furnish names of interested individuals and groups in each county, so that county medical societies can be informed regarding personnel to contact in order to initiate the establishment of councils in their areas. It was agreed that Mr. Milliken would be given names of the appropriate members of a given county medical society, with whom he can work when he conducts health council organization activities in that area.

With regard to disposition of questions concerning the operation and funds available under the Federal Hospital Construction Act and concepts of health centers, Mr. Milliken requested and received the suggestion that rural people be advised to await clarification of the Ohio Master Plan and of the health center matter before acting; but in the meantime to organize a coordinated county council which may well provide efficient promotion of the project when applications for funds are released.

EXHIBIT TO BE PREPARED

The problem of Brucellosis in rural areas was brought up by Mr. Milliken. The committee recommended to The Council that literature, exhibits, and other information material regarding a preventive educational campaign against this disease be developed by the Ohio State Medical Association. The committee also emphasized the necessity of reporting incidence of the disease to local health departments.

The Ohio State Medical Association Survey of Medical Students, Interns, and Residents, with regard to rural medical practice was then taken up.

The committee asked that the deans of the three medical schools be requested to furnish information as to the origin of members of the present freshman medical class with regard to

rural and urban classification of origin. It was also suggested that a series of lectures on the advantages and disadvantages of rural medical practice be recommended to the deans of the medical schools.

DEFINITE RECOMMENDATIONS

The Committee ordered that the Summary and Comments resulting from the above survey be submitted to The Council and to the deans of the medical schools, suggesting that The Council consider the summary for publication in *The Journal*.

In line with the results of the above survey, the committee made the following recommendations to The Council:

1. That the subsidization of rural physicians to encourage them to establish a rural practice should not be undertaken.

2. That a study be made of the feasibility of establishing some type of rural scholarship in medicine for boys with good backgrounds from rural high schools. If such a scholarship be established, no obligation as to repayment of the money, or specification as to type or area of practice should be included.

3. That the attention of medical educators be directed to the final paragraph of the Summary, regarding "a revamping of medical school curriculum . . . to include more about the diagnosis and treatment of the common diseases, and routine office practice"; and the medical schools give greater attention to this problem; also that this matter be brought to the attention of hospitals in the training of interns.

The committee requested that Mr. Hart F. Page of the State Headquarters Staff, prepare copy for a pamphlet on rural health problems, to be submitted for committee approval.

The Chairman discussed methods of increasing rural enrollment in Ohio Medical Indemnity, Inc., "The Doctors' Plan," for prepaid medical care.

It was suggested that the Chairman approach the Ohio Rural Health Council with the proposal that it take the leadership in a program for the recodification of Ohio Health Laws.

ANALYSIS OF SURVEY

Slightly over 80 per cent of Ohio's junior and senior medical students, interns, and residents have indicated that they intend to enter urban practice upon completion of their formal education, while 14 per cent plan to practice in rural areas, according to the survey conducted by the committee and referred to previously in this report. The survey was made in 1947, with the cooperation of Ohio's three medical schools and many Ohio hospitals.

A total of 591 future doctors of medicine participated in the survey, and stated their views on the problem of finding country practitioners and some offered opinions of their own regarding

methods which may be used to deal with the issue.

WHY CITIES PREFERRED

The primary reason given for the overwhelming preference for city practice was the lack of facilities, including hospital, diagnostic, and consultative aids in rural territories. Of those who favored urban practice, 32.8 per cent gave this reason. In 30 per cent of the cases the main factor of choice was the fact that rural practice would preclude the pursuance of a specialty. Of the remainder, 22.8 per cent were influenced by the desire for urban life and culture for themselves and for their families.

Of those who chose rural practice, 50 per cent indicated a preference for rural life. Half of these indicated that they were of rural origin. About 25 per cent cited the need or opportunity as the reason for their choice.

In dealing with possible solutions to the problem of attracting more physicians to the farm areas, the Committee offered a number of inducements which have been proposed at various times by interested groups, and requested opinions concerning each.

THIS PLAN APPROVED

Concerning a hypothetical proposal that "the community establish and maintain a community medical center to furnish X-ray and laboratory facilities and a small emergency unit, with beds, all available for the use of the local physician or physicians," 80 per cent said that it was a good plan, while 36.7 per cent indicated that the existence of a project of this sort would influence their decision on the location of practice.

Since a large number of the group have already chosen their field, a high percentage of influence of a proposal of this sort could not have been expected. However, it received great favor as an inducement "for the other fellow."

VOTE ON OTHER IDEAS

Regarded in apparent disfavor was another hypothetical situation wherein the community or individuals "would assist financially in the education of a certain medical student with the understanding that he would be obligated later to establish in the community which assisted him." An even 77 per cent of those surveyed dubbed this a poor procedure and only four persons said that such a plan would influence their decision. This is to be expected, however, as the group surveyed has its formal education practically completed.

Most evenly divided was the opinion as to the merits of a hypothetical suggestion that "a guaranteed minimum income be provided to a physician during the first few years of practice in a rural area." A total of 251 thought it a good plan, while 296 declared that it was not. Only 30 indicated that their decision might be influenced

by a project of this sort, while 526 said otherwise. The usual comment concerning this plan was that it is not necessary in these economic times, and that it might contribute to mediocre medicine.

Most enthusiastic response came from a question regarding the feasibility of an externship with a rural physician as an extracurricular part of medical training conducted under the supervision of medical schools. A total of 401 said that they definitely desired this as a part of their education; 160 were against such a procedure, while 30 did not answer.

Some doubted the time or ability of the average rural physician to engage in this project, but for the most part, those surveyed thought that the time would be well spent as an opportunity to, as several stated, "learn the art of medicine." Many asked about possible remuneration to the student while serving in such a capacity.

FAVOR GROUP PRACTICE

A number of the men surveyed volunteered the opinion that the most satisfactory answer to the rural problem is group practice and proceeded to make a case for this type of setup. One declared,

"My hope, and that of two friends, is to establish a group of specialists in a medium-sized town which is the center of a large area without adequate medical care. We hope to establish a small center which will be self-sufficient, will have enough facilities to provide the standard diagnostic and therapeutic aids, and will be able to serve the people at a cost below that of ordinary specialist care. Our hope is that by a system of medical insurance, this will be possible."

Others commented that the answer is to get more rural boys into medical school, subscribing to the theory that those who are reared in a rural community are most likely to want to practice medicine in such an area.

CURRICULUM NEEDS CHANGING

A revamping of medical school curriculum was suggested by several of the men, and there was apparent a dissatisfaction on the part of a number of those who wished to enter the general practice of medicine as to the material offered by various medical colleges. These institutions were blamed by some for leading the students toward the specialties. These men wanted to know more about the diagnosis and treatment of the common diseases, and routine office practice.

Dr. Ernest F. Krug, consulting ophthalmologist at Lennox Hill Hospital, New York, a native of Cleveland, and the son of Professor Joseph Krug, supervisor of German in Cleveland public schools, died Feb. 28.

Is Your Room Reserved for the A.M.A. Annual Session?

Physicians planning to attend the 97th Annual Session of the American Medical Association in Chicago, June 21-25, are advised to make their hotel reservations immediately. Applications for hotel accommodations should be made to Dr. Fred H. Muller, Chairman, Sub-Committee on Hotels, 105 W. Madison St., Room 1707, Chicago 2, Ill. An announcement giving rates for leading hotels and an application form appeared in the March 13 issue and previous issues of *The Journal of the American Medical Association*.

Several Hospital Projects Being Considered for Federal Aid

Four projects for hospital construction under the Federal Hill-Burton Law were ready to be processed by the Ohio Department of Health, under direction of Dr. John D. Porterfield, at the time this article was written, and subsequent to approval by the department would be recommended to the Surgeon General of the U.S. Public Health Service for favorable action.

Five other projects were being considered and a number of others of equal high priority were pending in the Hospital Facilities Office of the Department.

The hospital projects ready to be processed, with approximate over-all cost involved, are: Washington Court House, \$529,000; Ashtabula, \$1,274,000; Xenia, \$1,214,000, and Nelsonville, \$1,176,000.

Respective figures quoted are estimated total cost of projects, including cost of construction, equipment and other expense items specified in requirements for participation. One-third of the amounts will come from the Federal grant-in-aid funds. The remaining two-thirds is on hand in respective communities. One-third of the four projects represents a little more than half of the \$2,692,125 of Federal funds available for the current fiscal year.

Among other projects receiving favorable consideration were those at Bowling Green, Defiance, Wilmington, Urbana and Dover. All of the towns named are in high-priority areas and have funds available for hospital construction.

A summary of the Ohio Hospital Plan for participating in Federal Funds under the Hill-Burton Law (Public Law 725), was given in the March issue of *The Journal*. With it was given the priority list of areas compiled as a result of the hospital need survey of the State.

Hospital Facilities and Mental Hygiene Programs for Rural Areas Discussed at State-Wide Conference

A TOTAL of 258 persons from 60 counties of Ohio attended the Fourth Annual Conference on Rural Health, sponsored by the Ohio Rural Health Council, March 1 and 2, at the Southern Hotel, Columbus.

The subject for discussion the first day was "Hospital Facilities and Health Centers." The program began with a talk on "The Status of the National Program," by Joseph W. Fichter, Master of the Ohio State Grange, followed by a report on "The State Survey and Master Plan", by John D. Porterfield, M.D., Director of the Ohio Department of Health. In an additional allotment of time Dr. Porterfield also discussed plans for consolidation of local health units.

During the afternoon the conference divided into four groups. These groups completed "affirmative and negative" questionnaires on the day's subject and subsequently reported their findings back to the conference as a whole, and group discussion was led by J. P. Schmidt of the department of rural economics and sociology, Ohio State University.

HOSPITAL RECOMMENDATIONS

Regarding the subject, "Hospital Facilities and Health Centers," it was generally agreed that in order to obtain adequate hospital facilities and health centers on a local level, the community itself must recognize the need and instigate a program to meet it.

This may be done, according to the conference opinion, by organizing a coordinated community health council, representative of all lay and professional groups. This council, it was said, should have a sub-committee to collect facts as to needs, and to study sources of revenue. After this study is assembled, the council should educate the general public and gain its support.

In addition to supporting the hospital building program it was recommended that the council might also promote health education, the improvement and coordination of public health services and facilities, adequate financing of health services, proper health legislation, and increased enrollment in nursing schools.

It was said that communities should be given suggestions and advice as to methods of raising the necessary local funds to finance hospital or health center projects; and that when built, the institutions should be centrally located, well administered, well equipped, and properly staffed.

HEALTH AND CONSERVATION

At a dinner, held the evening of the first day, the conference was addressed by Paul C. Landis, supervisor of health, physical education, recrea-

tion and safety, State Department of Education, on the subject, "Home and Community Health Education Programs;" and by W. M. Landess, Knoxville, Tennessee, Division of Agricultural Relations, Tennessee Valley Authority, who spoke on "Soil Minerals and Our Diets."

The second day of the conference was devoted to a discussion of "Mental Health." Speakers were Dr. E. J. Humphreys, acting commissioner of mental hygiene, State Department of Public Welfare, speaking on "Emotional Adaptations in Health;" A. R. Mangus, department of rural economics and sociology, Ohio State University, and Dr. Roger M. Gove, director of the Miami County Guidance Center, on findings at that center.

After the above papers, the conference was divided in the same manner as the previous day for group discussion.

MENTAL HYGIENE RECOMMENDATIONS

General findings were that each county should develop a continuous mental health program, with the organizing of such a program in the hands of the existing coordinated community health council.

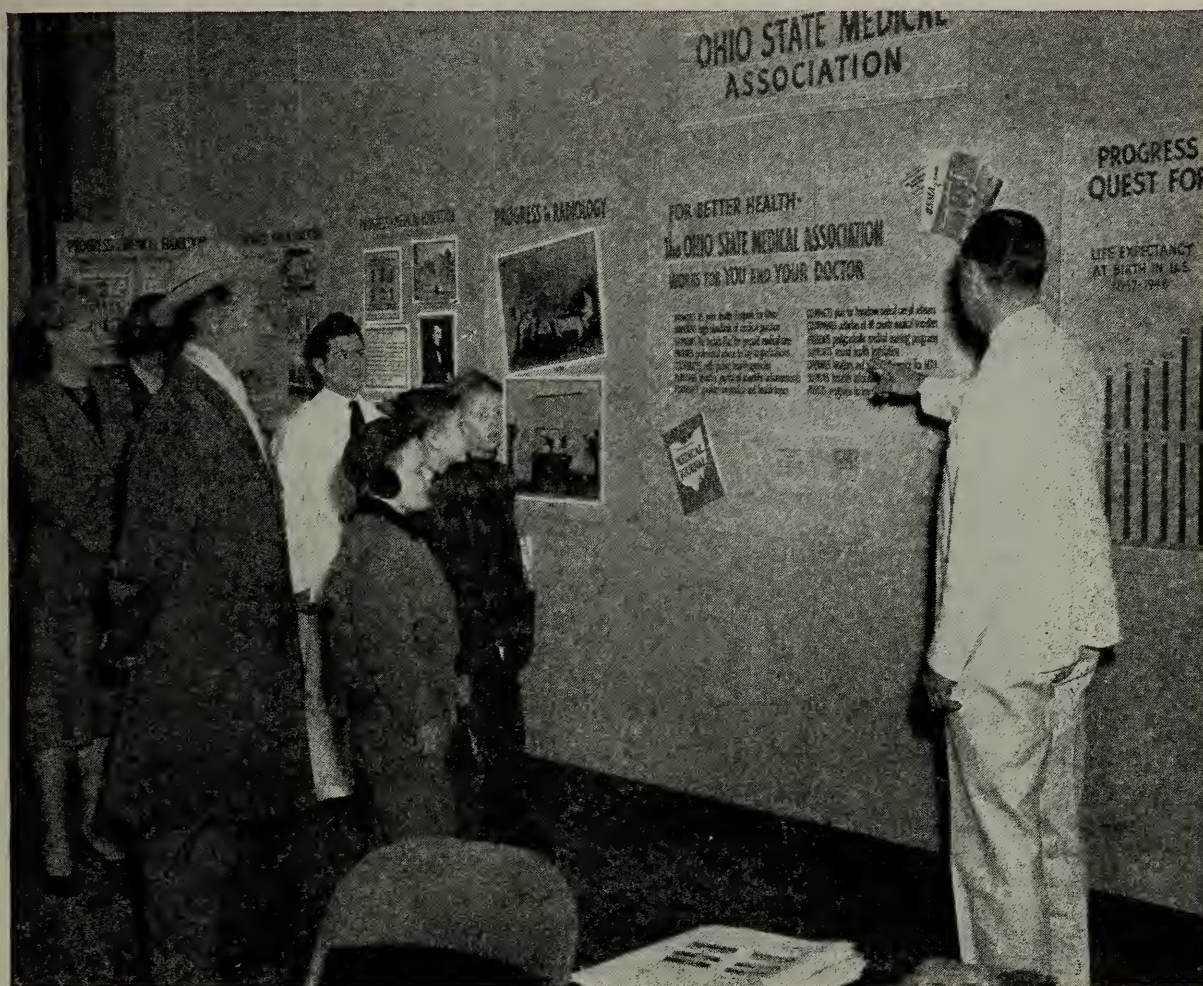
It was stated that the attack on the problem of mental health should include remedial services, educational and preventive services, support of state legislation, continuing program of research, and influence on schools to give added emphasis in preparing children for sound emotional as well as physical and mental living. Special emphasis, it was said, might be placed on parent-children relationships, premarital counseling, and study of juvenile delinquency.

The conference advised that it may not be feasible for each county to have at this time a program as comprehensive as that of Miami County, including a guidance center and full-time staff. However it was urged that all counties should immediately undertake a program of public education on problems of mental health.

O.S.M.A. REPRESENTED

Among those attending the conference were: Dr. Jonathan Forman, member of Committee on Rural Health, Ohio State Medical Association, and from the State Association Headquarters Staff, Charles S. Nelson, executive secretary; George H. Saville, director of public relations; Hart F. Page, assistant director of public relations; and R. Gordon Moore, assistant managing editor of *The Journal*. Mr. Nelson served as the leader of one of the four main discussion groups. A number of physicians from different parts of the State also attended.

O.S.M.A. Display One of the Features at Akron "Health Day" Exhibit Sponsored by the Woman's Auxiliary



A POSTER display by the Ohio State Medical Association depicting progress in the quest for health, and services of the Association to the medical profession and the public, was one of the features of the "Health Day" exhibit sponsored by the Woman's Auxiliary to the Summit County Medical Association, Feb. 6-7, at Akron. Over 2,000 persons viewed the exhibit which was housed in the auditorium of O'Neil's Department Store, and well-publicized by press and radio.

Photographic panels and posters were used to interpret progress in the fields of surgery, medicine, anesthesiology, roentgenology, tuberculosis control, and immunization.

The history and development of Ohio's three medical schools, the Ohio State University College of Medicine, Columbus, Western Reserve University School of Medicine, Cleveland, and the University of Cincinnati College of Medicine, Cincinnati, were shown in a series of three panels.

Another poster showed the gain in life ex-

pectancy at birth from 37 years in 1846 to 68 years in 1946.

BOOKLETS DISTRIBUTED

Available without cost at the Ohio State Medical Association's exhibit were health education booklets on such subjects as: How to be an intelligent patient, sex education for the adolescent, emotional health, appendicitis, high blood pressure, heart attack, annual checkups, hearing aids, cancer, feeding problems, diet and nutrition, acne and contagious diseases. Over 6,500 copies of these pamphlets were distributed, along with 500 free copies of the magazine *Hygeia*. Dr. Charles K. Wintrup, resident in medicine at People's Hospital, Dr. John Bender, intern at Akron City Hospital, and George H. Saville, director of public relations of the Ohio State Medical Association, were on duty to answer questions and to explain the exhibit.

OTHER EXHIBITORS

Other exhibitors included: City Hospital, blood bank; St. Thomas Hospital, intravenous solu-

tions; Children's Hospital, polio treatment equipment; People's Hospital, electrocardiogram and medical social service; Y.W.C.A., athletic activities; Akron Child Guidance League, books; Akron Public Library, books on health; Akron League of Nursing Education, pamphlets and pictures from various nursing schools; Akron Board of Education, audiometer and books; Y.M.C.A., health activities; Girls Scouts, volunteer hospital aide program; Boy Scouts, posters, camp sanitation.

Summit County Health Department, well-baby clinics, rural dental health, and rabies exhibit; Akron City Health Department, public health nursing, restaurant inspection, rat control, water works, sewage disposal; Akron Dairy Council, role of milk in health; Jewish Center, athletic program; Junior Chamber of Commerce, eye bank; Community Service Association, blood bank posters; Visiting Nurses' Association, new kit; Summit County Cancer Control, literature; Summit County Tuberculosis Association, pamphlets; Red Cross, home nursing, first aid, and water safety; Home and School League, school health program; Cleveland Health Museum, food facts and fallacies display; Akron Hospital Service and Ohio Medical Indemnity, Inc., Blue Cross and The Doctors' Plan.

COMMITTEE IN CHARGE

The Health Day exhibit was arranged by Mrs. John Paul Sauvageot, chairman of the Public Relations Committee of the Woman's Auxiliary to the Summit County Medical Society; Mrs. R. F. Jolley, co-chairman; Mrs. R. M. Lemmon, president of the Auxiliary; the following members of the committee, Mrs. Milton Friedman, Mrs. E. W. Breyfogle, Mrs. L. M. Weinberger, assisted by Mrs. Morris Kalmon, Mrs. Earl Burgner, Mrs. Roger Q. Davis, Mrs. Frank Bly, and Mrs. H. K. Harrington.

The poster display of the Ohio State Medical Association is available for use by any county medical society or woman's auxiliary. Requests should be addressed to the State Headquarters Office, 79 E. State St., Columbus.

Activities of The Editor

On Tuesday evening, March 2, Dr. Jonathan Forman, editor of *The Journal*, appeared by transcription on Bob Elsar's program on radio stations in New York, Philadelphia, Detroit, St. Louis, and Los Angeles; and on March 6 on "Generation Indicted" over station WLW.

On March 3, Dr. Forman was guest speaker at the Annual Meeting of the Union County Soil Conservation District at Marysville.

At Columbus, Dr. Forman in February addressed a meeting of the Franklin Garden Club of Columbus on "Youth Health and Your Garden."

Also in February he was principal speaker in

Hillsboro at a meeting of the Ohio Soil Conservation District No. 1.

In February he addressed the Annual Meeting of The Columbus Fruit and Vegetable Growers Co-operative on "How You Can Take Care of Your Health by Taking Care of Your Soil."

On February 26, Dr. Forman addressed the annual fathers-sons' dinner of the Masonic Lodge of New Holland, on the subject, "Your Stewardship of Your Land."

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Blue Shield has been adopted as the official name and insignia for the non-profit, prepayment medical care plans in the United States, as a result of action taken by the Commission of Associated Medical Care Plans. Ohio Medical Indemnity, Inc., sponsored by the Ohio State Medical Association, is entitled to use the insignia, and will do so. The adoption of Blue Shield will not replace the Seal of Acceptance of the A.M.A., awarded by the Council on Medical Service to prepayment plans which have complied with established minimum standards. Before A.M.C.P. accepts a prepayment plan as a full member, entitling that plan to use the Blue Shield insignia, the A.M.A. minimum standards must be fulfilled.

* * *

On January 1, 1948, the 48 non-profit medical care plans recorded a total enrollment in excess of 7,000,000 persons.

* * *

Plans have been prepared for submission to the executive council of the Canadian Medical Association, calling for the establishment of Canadian Associated Medical Plans, similar to Associated Medical Care Plans in the United States.

* * *

With the release of 1947 enrollment reports, two Blue Shield plans had passed the 700,000 mark in enrollment. United Medical Service, New York City, reported a total enrollment on December 31, 1947, of 729,794 persons, while Massachusetts Medical Service reported, as of the same date, an enrollment of 725,519. Michigan Medical Service still tops the list with 935,531 persons enrolled. Ohio Medical Indemnity, one of the younger plans, has an enrollment of about 320,000.

* * *

The physicians in Nebraska have approved the adding of service benefit guarantees for the subscriber members of the Nebraska Medical Service (Blue Shield Plan).

* * *

On January 1, 1948, because of crowded conditions in the A.M.A. headquarters, A.M.C.P. moved into larger offices in the Insurance Center Building at 330 South Wells Street in Chicago.

Organized Health Activities Are Chief Topics at Presidents and Secretaries Conference

IN spite of a two-inch snow which blanketed the highways on February 22, the Annual Conference of Presidents and Secretaries of County Medical Societies of the Ohio State Medical Association, at the Fort Hayes Hotel, Columbus, drew a good representation from all parts of the State. The final count showed 115 persons in attendance.

Following a get-acquainted session and period of registration, Dr. Ralph L. Rutledge, Alliance, president of the Association, called the conference to order. After an address of welcome, Dr. Rutledge outlined highlights of the Association's activities for the year.

SCHOOL HEALTH PROGRAM

"Medical Leadership in School Health Programs" was the title of an address by Dr. Thomas E. Shaffer, Columbus, school physician, University School, Ohio State University.

The second subject address on the program was "The Role of the County Medical Society in Cancer Control." The subject was discussed by Dr. John H. Lazzari, Cleveland, chairman of the Association's Cancer Committee.

District councilors had an opportunity during the final period of the morning to meet with presidents and secretaries of societies within their districts. The periods were given over to discussions of local problems and activities, and to drafting questions to be submitted later in the program.

HENDRICKS SPEAKS

Luncheon was served in the Gold Room after which Thomas A. Hendricks, Chicago, secretary, Council on Medical Service, American Medical Association, opened the afternoon program with an address entitled, "Some Things You Should Know About the A.M.A."

"What Can Be Done To Improve Ohio's Local and State Health Departments?" was the subject of a talk by Dr. John D. Porterfield, director, Ohio Department of Health.

V. A. PROBLEMS

Dr. Peter A. Volpe, newly appointed medical director for the Veterans Administration in Ohio, Michigan, and Kentucky, discussed the subject, "Policies and Procedures of the Veterans Administration Medical Care Program."

Final feature on the program was the "Information Please" session, during which questions on subjects discussed and on matters of general interest were received from the floor and answered by the speakers and others specially qualified in the respective fields. Charles S.

Nelson, executive secretary of the Association, was moderator.

THOSE IN ATTENDANCE

Officers, Councilors, and committeemen of the State Association present were: Dr. R. L. Rutledge, Alliance; Dr. E. O. Swartz, Cincinnati; Dr. H. C. Messenger, Xenia; Dr. J. Craig Bowman, Upper Sandusky; Dr. Carl S. Mundy, Toledo; Dr.

All presidents and secretaries of county medical societies will receive a detailed report of the 1948 Conference of Presidents and Secretaries of County Medical Societies only a summary of which is given herewith. The report will be mailed as soon as copies are available.

Paul A. Davis, Akron; Dr. Chester P. Swett, Lancaster; Dr. Gilbert Micklethwaite, Portsmouth; Dr. H. M. Clodfelter, Columbus; Dr. Frederick P. Osgood, Toledo; Dr. William M. Skipp, Youngstown; Dr. Clyde M. Fitch, Portsmouth; Dr. Jonathan Forman, Columbus; Dr. W. W. Green, Toledo; Dr. Drew L. Davies, Columbus; Dr. Gordon G. Nelson, Youngstown; Dr. Thomas E. Rardin, Columbus; Dr. John H. Lazzari, Cleveland; Dr. Dwight M. Palmer, Columbus; Dr. C. C. Sherburne, Columbus; Dr. E. A. Ockuly, Toledo; Dr. H. M. Platter, Columbus; Dr. J. M. Painter, Kent; Dr. J. W. Wilce, Columbus; Dr. Frank M. Wiseley, Findlay; Dr. Richard E. Meiling, Columbus; Dr. Thomas E. Shaffer, Columbus.

Representatives of the county medical societies present were: First District—Adams County, Dr. Hazel L. Sproull; Butler County, Dr. Walter Reese, Dr. Fred Brosius and Dr. C. T. Atkinson; Highland County, Dr. L. D. McBride and Dr. W. B. Roads; Warren County, Dr. A. F. Lippert. Second District—Clark County, Dr. F. A. Halloran and Dr. H. H. Ingling; Darke County, Dr. John R. Alley and Dr. Maurice Kane; Greene County, Dr. David Taylor; Miami County, Dr. E. R. Irvin, Dr. G. A. Woodhouse; Montgomery County, Dr. N. C. Hochwalt, Dr. T. L. Light and Dr. Paul Troup. Third District—Auglaize County, Dr. Guy E. Noble; Hancock County, Dr. Lawrence H. Goodman; Hardin County, Dr. Floyd M. Elliott; Logan County, Dr. Omar C. Amstutz; Seneca County, Dr. C. W. Consolo and Dr. Walter Daniel; Van Wert County, Dr. R. E. Shell. Fourth District—Lucas County, Dr. Howard Holmes; Ottawa County, Dr. Cyrus R. Wood and Dr. Gordon R. Ley; Wood County, Dr. Paul F. Orr. Fifth District—Cuyahoga County, Dr. C. W. Wyckoff; Geauga County, Dr. Phillip P. Pease. Sixth District—Mahoning County, John Noll; Portage County, Dr. Walter B. Webb and Dr. E. J. Widdecombe; Stark County, Dr. G. L. King and Dr. Robert E. Tschantz; Summit County, Dr. Robert M. Lemmon; Trumbull County, Dr. E. G. Kyle and Dr. E. G. Caskey. Seventh District—Belmont County, Dr. Leo D. Covert and Dr. Bertha M. Joseph; Tuscarawas County, Dr. Burrell Russell and Dr. H. F. Wher-

ley. Eighth District—Fairfield County, Dr. R. S. Bode and Dr. C. W. Brown; Licking County, Dr. Dale E. Roth and Dr. L. H. Miller. Ninth District—Gallia County, Dr. Homer B. Thomas; Lawrence County, Dr. Ray Swango; Scioto County, Dr. Elizabeth Long and Dr. J. P. McAfee. Tenth District—Delaware County, Dr. W. E. Borden and Dr. F. M. Stratton; Fayette County, Dr. A. D. Woodmansee and Dr. Joseph M. Herbert; Knox County, Dr. Robert Hoecker; Morrow County, Dr. J. P. Ingmire and Dr. F. M. Hartsook; Pickaway County, Dr. Walter F. Heine; Ross County, Dr. R. C. Bane; Union County, Dr. A. M. Johnston. Eleventh District—Ashland County, Dr. H. Wayne Smith; Erie County, Dr. H. G. Lehrer; Holmes County, Dr. Luther High and Dr. Owen Patterson; Huron County, Dr. C. J. Cranston and Dr. George F. Linn; Medina County, Dr. Morris Wilderom; Richland County, Dr. Paul A. Blackstone.

Also attending were the following: Dr. John D. Porterfield, Columbus, Dr. W. B. Lacock, Columbus, and Dr. Paul Peterson, Columbus, Ohio Department of Health; Dr. A. S. Speier, Cincinnati, Dr. Peter A. Volpe, Columbus, and Dr. S. D. McCoy, Columbus, Veterans Administration; T. A. Hendricks, Chicago, American Medical Association; the following executive secretaries of county societies—H. Van Y. Caldwell, Cleveland, Frank C. Bateman, Springfield, R. W. Elwell, Toledo, Robert F. Freeman, Dayton, Stanley Mauck, Columbus, and Ray Swink, Cincinnati, and executive officers and staff members of the Ohio State Medical Association.

Conditions for Silicosis Claim Under O. I. C. Are Outlined

Exposure by the claimant over a period of not less than three years to silica dust is one of eight conditions which a claim for silicosis must meet before it will be considered valid by the Ohio Industrial Commission, according to a paper presented by Lester M. Merritt, safety advisor for the O. I. C., before the annual meeting of the Ohio Ceramic Industries Association.

The requirements which a claim must meet are based on ten years of experience by the commission in dealing with claims. Since the Ohio Legislature made silicosis compensable on July 31, 1937, a total of 1,150 persons have been allowed claims for the industrial disease.

The foundries produced 57 per cent, or 655 cases, of which 161 were in steel foundries, 365 in iron foundries, and 129 in the non-ferrous foundries. The various industries of the ceramic field were next in line with 340 cases, or 29.6 per cent of the total.

Percentages of claims from other classes of industries were as follows: Bricklayers in steel and glass industries, 4.0 per cent; sandstone quarries and cut stone industry, 4.8; polishing, buffing, and grinding of metals, 1.2; coal mining where sandstone or silicious shale was present, 0.7; various other industries, 2.7 per cent.

Following is a summary of the conditions which a claim must meet if it is to be considered valid:

1. The claimant must show that he has been

exposed to silica dust for a period of not less than three years, some portion of which must have been after the effective date of the Act.

2. Claims must be filed within one year after total disability began or within such longer period as shall not exceed six months after diagnosis of silicosis by a licensed physician.

3. Payment can be made only in the event that disability or death resulted within eight years after the last injurious exposure.

4. Payment is made only in event of temporary total disability, permanent total disability or death, except for the purpose of changing employment, then the claimant may be paid \$10 per week for 26 weeks.

5. Claims of dependents on account of death must be made within six months after death.

6. Before awarding a claim the Industrial Commission must submit the claim to a Board of Silicosis Referees, which consists of three physicians, one of whom is a roentgenologist.

7. The amount of compensation for total disability is awarded at a rate of 66-2/3 per cent of the claimant's average weekly wages, not to exceed \$25 per week, nor less than \$10 unless the weekly wage is less than that amount. Death payments are based on a \$7,500 maximum.

8. A claimant not satisfied with the order of the Industrial Commission may file an application for review by a medical board of review whose majority vote shall be binding.

Mahoning P-G Assembly Scheduled For Wednesday, April 14

The Mahoning County Medical Society will hold its 20th Annual Postgraduate Assembly on Wednesday, April 14, at the Hotel Pick-Ohio, Youngstown.

The morning session will be divided into two sections. The Medical Clinic will be held at St. Elizabeth's Hospital under direction of the following staff members of the University of Illinois College of Medicine: Dr. John B. Youmans, Dr. Robert W. Keeton, and Dr. Willard O. Thompson. The Surgical Clinic will be held at Stambaugh Nurses' Home, South Side Unit Youngstown Hospital, under direction of Dr. Eric Oldberg and Dr. John T. Reynolds, also of the University of Illinois.

The afternoon program will consist of the following: "Anemia of Nutritional Origin," Dr. Youmans; "Feeding the Sick Patient," Dr. Keeton; "Protruded Intervertebral Discs," Dr. Oldberg; "Intestinal Obstruction," Dr. Reynolds; and "Uses and Misuses of the Sex Hormone," Dr. Thompson.

Following a dinner at 6:30 p. m., Dr. Thompson will lead a round-table discussion at 8 p. m. on "Current Problems Facing Medicine."

Do You Know? . . .

Streptomycin production during 1947 amounted to 9,687,049 grams, as against only 1,132,000 grams in 1946, according to the Department of Commerce.

* * *

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, addressed the Columbus post of the American Veterans Committee recently on "Current Health and Medical Legislation."

* * *

During the past two years the Eye-Bank For Sight Restoration, Inc., New York, has accepted 600 eyes from the public, of which 90 per cent were used for transplantation. Eyes not suitable for the operation were used for research.

* * *

The American Medical Golfing Association will hold its thirty-second tournament at Olympia Fields Country Club, Chicago, Monday, June 21, in connection with the Annual Session of the American Medical Association. Details can be obtained by writing the secretary, Bill Burns, 2020 Olds Tower, Lansing 8, Mich.

* * *

Dr. Charles Shook, Toledo, medical director of the Owens-Illinois Glass Company, will be one of the speakers during the Eighteenth All-Ohio Safety Congress, to be held at the Neil House, Columbus, April 13-14.

* * *

The University of Kansas Medical Center, in cooperation with the other three hospitals in Kansas City, has established a one-year residency in general practice to begin July 1, 1948.

* * *

All patients in the State's welfare-institutions are going to be vaccinated against tuberculosis with BCG this summer. The State departments of health and welfare and the United States Public Health Service are cooperating in the program. A similar project will start in Cleveland, July 1, for the protection of student nurses in 10 Greater Cleveland hospitals.

* * *

Dr. Charles E. Holzer, Sr., Gallipolis, has been re-elected to his 15th term as president of the Ohio Valley Conservation and Flood Control Congress.

* * *

The annual outstanding citizen award of the East Liverpool Junior Chamber of Commerce, was presented recently to Dr. C. H. Bailey for "service for humanity" during the 37-years he has been a physician and surgeon in the community.

Wartime acceleration at the University of Cincinnati College of Medicine closed with the graduation of 76 doctors of medicine at the 129th commencement exercises, February 7. This will be the final off-season commencement. The next class in medicine will receive degrees at regular June graduation ceremonies in 1949.

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Dr. Jonathan Forman, Columbus, and Dr. Karl D. Figley, Toledo, are scheduled to speak at the Southwest Allergy Forum April 5-6, at the Biltmore Hotel, Oklahoma City.

* * *

The National Safety Council reports that 100,000 persons died in accidents during 1947 and 10,500,000 were injured, with the resulting economic loss of \$6,700,000,000. Home accidents deposited traffic accidents as the nation's No. 1 killer. There were 33,500 deaths from home accidents and 32,000 motor vehicle fatalities.

* * *

According to *Hygeia*, two outstanding scientists have estimated that, as a result of medical progress based chiefly on animal experimentation, people born in 1943 will live 16 years longer than those born in 1902.

* * *

Radio station WTAG, Ashland, has been broadcasting the recorded programs of the Bureau of Health Education of the American Medical Association twice weekly since September, 1947, under the auspices of the Ashland County Medical Society. The arrangement was made through the society's Committee on Public Relations, of which Dr. Herman M. Gunn is chairman.

* * *

Dr. G. W. Flory, Eaton, veteran Preble County physician, recently celebrated the 60th anniversary of his graduation from the Physio-Medical College, Indianapolis, with Dr. J. H. Kinsey, Richmond, Ind., the only other living member of the graduating class of 1888.

* * *

According to the United States Public Health Service, the national birth rate for 1947 was about 25.9 per 1,000 population, the highest since the birth registration area was established in 1915. The infant mortality rate was approximately 32.1, a decrease of 44 per cent in the last 11 years.

* * *

The National Foundation for Infantile Paralysis is sponsoring the First International Poliomyelitis Conference at the Waldorf-Astoria Hotel, New York City, July 12-17.

With the Veterans Administration —

Medical records of more than 100,000 World War II veterans will be used to aid researchers in their efforts to discover the causes and cures of little-known diseases and unusual injuries, the work being accomplished in cooperation with the Committee on Veterans Medical Problems of the National Research Council, National Academy of Sciences.

V. A. has 35 general research laboratories in operation in hospitals affiliated with class "A" medical schools. Six laboratories for radio-isotope research and therapy will be established in 1948 and three more in 1949.

A cardiovascular research unit now is in operation at the V. A. Mount Alto Hospital, Washington, D. C. Twenty V. A. hospitals are engaged in investigation of the value and limitations of streptomycin therapy in the various forms of tuberculosis. More than a half-million dollars in contracts for research into artificial limbs have been awarded.

Other projects to get under way include study on the value and limitations of vagotomy; evaluation of the usefulness and limitations of providing albumin therapy in liver diseases; and study of patients with sarcoidosis.

* * *

During the calendar year 1947, a total of 29,097 authorizations for prescriptions for veterans receiving medical care from the Veterans Administration were processed at the office of the Ohio State Pharmaceutical Association, Columbus, which is acting as an intermediary agency between pharmacists and the V. A. The total cost of prescriptions authorized was \$68,547.58. The average amount received by druggists per prescription authorized was \$2.35. In the Cleveland area the number of prescriptions processed for druggists was 15,144, at a cost of \$34,559.94, and in the Cincinnati area, 13,953, at a cost of \$33,987.64.

* * *

Any seriously disabled veteran, unable to devote as many hours per day to training under the Vocational Rehabilitation Act as the ordinary veteran trainee does, now may qualify for full-time training under specified conditions. Specified conditions may include those in which the veteran is physically unable to devote many hours to training, or shows promise that his work tolerance will increase more rapidly if he is working for a suitable objective.

* * *

Dr. Harvey J. Tompkins, Arlington, Va., has been appointed head of the neuropsychiatric service in the Veterans Administration Department of Medicine and Surgery. He succeeds Dr. Daniel Blain.

A reduction of 8,500 employees of the Veterans Administration for the fiscal year ending June 30 was announced recently. The planned reductions are to be made in services other than medical. No decreases are contemplated in the V.A. medical program for the balance of the fiscal year, according to Carl R. Gray, Jr., administrator of Veterans Affairs. In V.A.'s recommended budget for the fiscal year beginning July 1, 1948, an increase is proposed in the medical program, he declared.

* * *

World War II veterans are ineligible for training under the G.I. Bill or the Vocational Rehabilitation Act (Public Law 16) while they are taking training in certain courses financed by other Federal appropriations, the Veterans Administration ruled recently.

Certain courses financed by Federal appropriations are available to veterans as well as to other persons. Among such courses are: U. S. Public Health training programs; resident training programs in hospitals, clinics, medical or dental laboratories owned or operated by the U. S. Government; residency training for physicians and dentists in the Department of Medicine and Surgery of the V.A.

The restrictions do not apply to veterans enrolled under either law in V.A.'s training program for clinical psychologists. The ruling will not affect veterans training on-the-job under either law in those Federal agencies and establishments approved by V.A. to offer such training.

* * *

Blind veterans, who have been issued equipment by the V. A. to aid them in overcoming their handicap, may now obtain minor repairs to this equipment without prior V. A. approval. By presenting cards to any repair shop in any section of the country, blind veterans will receive repair service up to a limit of \$20 on such equipment as typewriters, radios, Braille writers, recording equipment, electric razors, etc.

Ophthalmology Exams Announced

Practical examinations by the American Board of Ophthalmology, Cape College, Me., have been scheduled as follows: Baltimore, May 20-25; and Chicago, Oct. 6-9. Written qualifying tests will be held annually, according to Dr. Everett L. Goar, Houston, chairman. Applications for the January, 1949, written qualifying test should be filed with the secretary before July 1.

In Memoriam

Augustus A. Babione, M.D., Luckey; University of Maryland School of Medicine and College of Physicians and Surgeons, 1903; aged 75; died Feb. 13; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1946. Dr. Babione practiced medicine in Luckey for the past 44 years. Surviving are his widow, two sons, one of whom is Capt. Robert W. Babione of the Navy Medical Corps, three brothers and five sisters.

Henry Randel Baremore, Jr., M.D., Akron; University of Vermont College of Medicine, 1913; aged 60; died March 4; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Baremore practiced medicine in Akron since shortly after the end of World War I, during which he was in the Army Medical Corps. He was a member of the Episcopal Church. Surviving are his widow, three daughters and a sister.

Edward Williams Barton, M.D., San Gabriel, Calif.; Medical College of Ohio, Cincinnati, 1901; aged 74; died Feb. 4; former member of the Ohio State Medical Association through 1925, and a Fellow of the American Medical Association. Dr. Barton, before World War I, practiced medicine in Akron where he is credited with helping to organize Peoples Hospital. He was vice-president of the Summit County Medical Society before going into the Army Medical Corps during World War I. He left Akron for California in 1922. Surviving are his widow and two daughters.

Charles Worcester Beaman, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1903; aged 68; died Feb. 25; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1946. Dr. Beaman practiced medicine in both Cincinnati and Columbus. He was a past-president of the Cincinnati Pediatric Society and past-president of the National Eclectic Medical Association. During World War I he served in the Army Medical Corps. He was a member of the Masonic Order. Surviving are his widow, four daughters and a son.

Travis Carroll, M.D., Cincinnati; University of Louisville School of Medicine, 1883; aged 86; died Feb. 24; former member of the Ohio State Medical Association and of the American Medical Association through 1932. Dr. Carroll practiced medicine in Hamilton County until his retirement about a year ago. Surviving are a

son, Dr. Harry R. Carroll, also of Cincinnati, a daughter and a sister.

Sherman Cook, M.D., Attica; Cleveland Medical College, Homeopathic, 1897; aged 76; died Feb. 19; former member of the Ohio State Medical Association and the American Medical Association through 1931. Dr. Cook practiced medicine in Attica since 1931. Prior to that he practiced in Henry, Defiance, Crawford, and Wayne Counties. He is survived by his widow.

Herman Clyde Duke, M.D., Richwood; Eclectic Medical College, Cincinnati, 1898; aged 72; died Feb. 7; member of the Ohio State Medical Association and Fellow of the American Medical Association; president of the Union County Medical Society in 1922, 1934, and 1941; secretary-treasurer in 1929-30; chairman of the legislative committee in 1929-30; delegate to the Ohio State Medical Association in 1942-43. Dr. Duke practiced medicine in Richwood for 50 years; he was a member of the Masonic Lodge. He was for 12 years on the Richwood School Board and was a member of the Board of Trustees of the Richwood Public Library. Surviving are his widow, a son and a daughter.

James H. Fiser, M.D., Malinta; Toledo Medical College, 1894; aged 84; died Feb. 18; member of the Ohio State Medical Association and the American Medical Association; president of the Henry County Medical Society in 1928 and 1930. Dr. Fiser practiced medicine in Malinta for 54 years. He is survived by his widow, a son and a daughter.

Thomas Alpheus Evans, M.D., Columbus; Rush Medical College, 1899; aged 76; died Feb. 4; former member of the Ohio State Medical Association and the American Medical Association through 1931. Dr. Evans practiced medicine in Columbus until his retirement in 1933. He served during the Spanish American War, and during World War I was in the Medical Corps. He was a member of the staff of the Veterans Bureau until his retirement and was a member of the Odd Fellows Lodge. Surviving are his widow, a son, a daughter, and three sisters.

Gilbert Edwin Garvin, M.D., Blanchester; Eclectic Medical College, Cincinnati, 1935; aged 42; died March 10 in an airplane crash; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Clinton County Medical Society in 1947 and 1948. During World War II he served in the Air Corps as flight surgeon. He was a member of the American Academy of General Practitioners; was a member of the

American Legion; and was on the staff of Our Lady of Mercy Hospital at Mariemont. Surviving are his widow and his mother.

Bruce Bentley Giffen, M. D., San Diego, Calif.; Ohio Medical University, Columbus, 1906; aged 68; former member of the Ohio State Medical Association and the American Medical Association through 1925. Dr. Giffen practiced medicine in St. Clairsville for 20 years before going to California in 1926.

Ralph Bolender Hannah, M. D., Georgetown; Miami Medical College, Cincinnati, 1896; aged 74; died Feb. 25; member of the Ohio State Medical Association and the American Medical Association; president of the Brown County Medical Society continuously from 1927 until the time of his death; chairman of the Legislative Committee from 1927 through 1947; delegate to the Ohio State Medical Association in 1947. Dr. Hannah practiced medicine in Georgetown for 50 years. Surviving are his widow, a son, a daughter and a sister.

Albert B. Headley, M. D., Cambridge; College of Physicians and Surgeons of Baltimore, 1902; aged 73; died March 5; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Guernsey County Medical Society in 1929 and secretary in 1919. Dr. Headley practiced medicine in Guernsey County for 46 years and since 1942 was county health commissioner. Surviving are his widow and one son.

Stanton Heck, M. D., Salem; Medical College of Ohio, Cincinnati, 1889; aged 86; died Feb. 17; former member of the Ohio State Medical Association and the American Medical Association through 1941; vice-president of the Columbiana County Medical Association in 1926 and its president in 1927. Dr. Heck went to Salem in 1892 where he practiced medicine until his retirement in 1939. He was instrumental in establishing the X-ray department of Salem City Hospital and was its head until his retirement. He was a member of the American Roentgen Ray Society and the Radiological Society of North America and held offices in both organizations. Surviving are his widow, a daughter, a son, a sister and a brother.

George Chauncey Jameson, M. D., Oberlin; University of Pennsylvania School of Medicine, 1893; aged 82; died Feb. 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Jameson practiced medicine in Oberlin for many years; he was for many years chief of staff at Allen Hospital and was one of the founders of the Oberlin Hospital Association. He was a member of the Congregational Church. Surviving are two sons.

Frank Kunz, M. D., Akron; University of Western Ontario Medical School, London, Ont., 1906; aged 65; died Feb. 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Kunz practiced medicine in Akron for 35 years where he was active in the Masonic Lodge. Surviving are his widow, a son, Dr. Franklyn Kunz, with whom he was associated in practice, and two sisters.

Matthew Gault Platt, M. D., Thornville; Cleveland-Pulte Medical College, 1914; aged 59; died Feb. 21; Dr. Platt practiced medicine for 20 years in Newark and for the past 10 years at Buckeye Lake. Surviving are his widow, one son and a step-daughter.

Albert H. Porter, M. D., Cleveland; Cleveland-Pulte Medical College, 1899; aged 81; died Feb. 14. Dr. Porter practiced medicine in Cleveland for 50 years. Surviving are his widow, three daughters and a sister.

Auguste Rhu, M. D., Marion; Western Reserve University School of Medicine, 1885; aged 98; died Feb. 27; member of the Ohio State Medical Association and the American Medical Association through 1947; president of the Marion County Academy of Medicine in 1925; member of the American College of Surgeons. Dr. Rhu practiced medicine for 63 years, 50 years of which were spent in Marion. In spite of his age, he continued his practice until shortly before his death. He was a member of the Masonic Lodge and the Order of Elks. He is survived by a son, Dr. Herman Rhu, also of Marion, and a grandson, Dr. Herman Rhu, Jr. a house surgeon at Syracuse Memorial Hospital, Syracuse, N. Y.

Frederick William Schilling, M. D., Louisville; Ohio Medical University, Columbus, 1895; aged 76; died Feb. 20; former member of the Ohio State Medical Association and the American Medical Association in 1938. Dr. Schilling spent his entire life in Louisville where he practiced medicine for approximately 52 years. He was a member of the Eagles Lodge. Surviving are his widow, one son, a sister and a brother, Dr. Charles E. Schilling, of Daytona Beach, Fla.

Anderson Lamb Smedley, M. D., Hamilton; Medical College of Ohio, Cincinnati, 1897; aged 74; died Feb. 29; former member of the Ohio State Medical Association through 1939. Dr. Smedley practiced medicine in Hamilton for 50 years prior to going to Pasadena, Calif., two years ago. He was a member of the Masonic Lodge and the Elks Lodge. Surviving are two sons.

Carl Louis Spohr, M. D., Columbus; Starling Medical College, Columbus, 1895; aged 77; died March 8; member of the Ohio State Medical Association and the American Medical Association.

tion. Dr. Spohr was professor emeritus of pathology and professor of clinical pathology at Ohio State University College of Medicine, where he served for 16 years. He formerly was assistant pathologist at the Ohio Epileptic Hospital, Gallipolis, and pathologist at Columbus State Hospital. Surviving are his widow, a son, Dr. L. Theodore Spohr, of New York, and three sisters.

Charles Edgar Welch, M.D., Nelsonville; Hahnemann Medical College and Hospital, Chicago, 1896; aged 77; died Feb. 18; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Athens County Medical Society in 1932 and president in 1933. Dr. Welch spent his entire professional career in Nelsonville. He was active in the Kiwanis Club, the Chamber of Commerce, the Elks Club, the Masonic Lodge, and the Pythian Lodge and was a member of the Methodist Church. He was also active in the business life of his community. Surviving are a sister and a half-brother.

Philip Henry White M.D., Cleveland; Illinois Medical College, Chicago, 1904; aged 72; died Feb. 7 in Selma, Ala. Dr. White practiced medicine for 45 years, 27 of them in Cleveland. He was a member of the Masonic Lodge and of the Baptist Church. Surviving are his widow, two sons, three sisters and a brother.

Dr. Harley Arthur Williams, M.D., Cleveland; Western Reserve University School of Medicine, 1929; aged 48; died March 5; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Cleveland Academy of Medicine in 1942; a Diplomate of the American Board of Internal Medicine; member of the American College of Physicians; assistant professor of clinical medicine, Western Reserve University. Surviving are his widow and an infant son.

Edith Rebecca Wolf, M.D., Cleveland; Cleveland University of Medicine and Surgery, 1896; aged 77; died Feb. 10 in Florida. Dr. Wolf practiced medicine in Cleveland and other northern Ohio cities. In 1901 she and her husband, the Rev. Frank D. Wolf, went to Portuguese Africa, where they served as missionaries for three years. She is survived by her husband, two daughters and a sister.

Pediatricians To Meet

An area meeting of the American Academy of Pediatrics will be held at the Hotel Schroeder, Milwaukee, Wis., June 28-30. Members of state medical societies are invited. Information may be obtained or registrations made by writing Dr. C. G. Grulee, secy.-treas., 636 Church St., Evanston, Ill.

CORRECTION IN V. A. FEE SCHEDULE

On page 3 of the Veterans Administration Fee Schedule, effective January 1, 1948, the paragraph headed "Example" should read as follows:

"A cardiologist authorized to conduct an examination of the heart, including an electrocardiogram (Item 0026), and who is also authorized to conduct a complete physical examination (Item 0012) will be paid a fee of \$15.00 (Item 0026) plus \$3.75 (one-half of Item 0012), or a total fee of \$18.75."

In the printed schedule mailed to all participating physicians, the figures \$4.00 and \$19.00 were used erroneously in place of \$3.75 and \$18.75, respectively.

Send in Your A.M.A. Directory Card Immediately!

The American Medical Association reports that 115,000 physicians have returned their Directory Information Cards supplying data for the new *American Medical Directory* now being compiled. Ohio physicians who have received these cards and have not returned them are urged to do so at once. This information is needed for listing in the 1949 Directory.

Please use the card that has been addressed to you, as it bears the serial number which has been assigned to your data. If a card is received by you addressed to another physician who has moved away, return the card with the doctor's new address written on the slip bearing his name and serial number if you can supply the information.

Before filling out your card, check the list of specialties on the back of the card and select only one specialty, indicating, in the space provided on the front of the card, either that your practice is limited to that specialty or that you give special attention to that branch of medicine along with general practice. Fill in the lines marked "Intern" and "Resident" only if you are now serving an internship or residency in a hospital.

A second request with a duplicate Information Card will be sent very soon to all physicians from whom cards have not been received so that they may have an opportunity to supply the necessary information for their listing in the Directory.

"The Role of Hormones in the Maintenance of Pregnancy" is the basis for the Schering Award for 1948. For the three best manuscripts submitted by undergraduate students of American and Canadian medical schools, the Schering Corporation of Bloomfield, N. J., is offering \$500, \$300, and \$200

Buckeye News Notes

Alliance—The urgency of the hospital membership and fund-raising campaign was outlined by Dr. Douglass S. King at a recent meeting of the Alliance Lions Club.

Ashland—Behavior problems of children were discussed by Dr. D. A. Weir, of Mansfield, at a January meeting of the Child Conservation League.

Ashtabula—Dr. Benjamin Norris, retired from the Army Medical Corps, and recently residing in San Diego, Calif., has been appointed health commissioner for Ashtabula County to succeed Dr. C. C. Crosby. Dr. Norris received his degree from Ohio-Miami Medical College, Cincinnati, in 1915.

Athens—Upon resignation of Dr. H. T. Phillips as health commissioner of the Athens City-County-Nelsonville Health District effective Jan. 1, Dr. L. I. Goldberg was appointed acting commissioner to serve until a permanent appointment is made.

Barnesville—Dr. D. O. Sheppard was the honored guest of a number of fellow physicians in celebration of his 50 years of practice of medicine.

Bluffton—Color slides of pictures taken in China while he was on Army duty there were shown at a meeting of the Kiwanis Club by Dr. F. D. Rodabaugh.

Cambridge—Dr. Arthur T. Hopwood addressed the Cambridge Junior Chamber of Commerce on occasion of National Heart Week.

Canton—Dr. John R. Seesholtz was appointed as a member of the Canton Board of Health for a five-year term to succeed Dr. J. E. Aten who asked that he be relieved at the expiration of his term.

Chagrin Falls—Members of the Chagrin Valley Men's Garden Club at their January meeting heard discussions on "Vitamins in Vegetables—Raw and Cooked", by Dr. H. V. Paryzek and Dr. E. F. Kieger, both of Pepper Pike.

Cincinnati—Reactivation of the Student Medical Association at the University of Cincinnati College of Medicine was announced early in January. Dr. Maurice Levine, professor and head of the department of psychiatry at the college, was the speaker at the first of a series of lectures sponsored by the group.

Cincinnati—"Cancer of the Colon", was the subject of a lecture by Dr. Paul Hoxworth of the University of Cincinnati College of Medicine, at a January session of Red Cross Nurses' Aides and other general hospital volunteers in the Surgical Amphitheatre at General Hospital.

Cincinnati—For the eighth time, Dr. F. W. Heinold was elected president of the Cincinnati Board of Education to serve during 1948.

Cincinnati—Dr. Walter R. Griess is the new chief of staff of Deaconess Hospital, succeeding Dr. K. V. Kitzmiller. Other officers are: Dr. Harold G. Reineke, vice-chairman; and Dr. A. B. Hendricks, secretary-treasurer.

Cincinnati—Dr. J. Philip Owens recently was appointed to succeed Dr. E. H. Schoenling as Hamilton County health commissioner. He is acting as assistant until Dr. Schoenling's resignation becomes effective in the near future.

Cincinnati—The February graduating class of the University of Cincinnati College of Medicine was addressed by Dr. Parke G. Smith of the college faculty.

Cleveland—The Cleveland Colored Chamber of Commerce re-elected Dr. Veo L. Beck president at a recent meeting.

Columbus—Dr. George H. Ruggy, junior dean of the Ohio State University College of Medicine, addressed a recent meeting of the Health and Safety Committee of the Business and Professional Women's Clubs. His subject was "Recent Advances in Medicine."

Columbus—Dr. Edward T. Kirkendall recently was named chairman of the staff of White Cross Hospital.

Columbus—"Medical Law in General Practice", was the topic of a talk by Dr. Thomas Sutherland, of Marion, lecturer in medical law at Ohio State University, at a January meeting of the American Academy of General Practice of Franklin County. Dr. P. B. Wiltberger, president pro tem of the organization, presented a paper on, "A New Test for Pregnancy in the First Trimester".

Coshocton—Dr. J. A. Foster, for 10 years a member of the Coshocton Board of Health and previously city health officer, retired from the board early in January.

Dayton—Major Lynn Mansfield, of Dayton, discussed the reserve officers' retirement program and the Ohio State veterans' bonus at a meeting of the Veteran Physicians of Montgomery County in the Biltmore Hotel, Dayton, Jan. 30.

Delaware—Dr. E. C. Jenkins discussed advances in surgical techniques and accomplishments in World War II at a recent meeting of the Delaware Rotary Club.

Delaware—The following officers were elected for 1948 at the January meeting of the staff of Jane M. Case Hospital, Delaware: Dr. William E. Borden, president and chief of staff; Dr.

“...pressure of the gravid
uterus mechanically
interferes...”

in pregnancy

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—Bockus, H. L.: *Gastro-Enterology*,
Philadelphia, W. B. Saunders
Company, 1946, vol. 3, p. 999.

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James G. Parker, vice-pres. and assistant chief of staff; Dr. George T. Blydenburgh, secy.-treas.

Eaton—In connection with National Heart Week, Dr. Robert A. Lyon of the University of Cincinnati Medical School, addressed members of the Eaton Lions Club.

Fremont—Two physicians were named among officers of the Sandusky County Board of Health. They are Dr. Glenn H. Walker, of Woodville, vice-president, and Dr. F. M. Teeple, Fremont, secretary.

Gallipolis—Newly elected president of the Gallipolis Shrine Club is Dr. Homer B. Thomas.

Hamilton—Dr. Garret J. Boone was appointed Butler County coroner to succeed Dr. Edward Cook who has served in that capacity for more than 30 years.

Hanoverton—Dr. H. J. Pelley, 83, was the subject of a feature article in the *East Liverpool Review* on occasion of his entering his 56th year of active practice.

Kent—Dr. Frank L. Meany, of Lakewood, spoke on "Plastic Surgery" before the February 2 meeting of the Woman's Club of Kent.

Lima—"Who Brought the Practice of Medicine Into Politics"? was the topic of a talk by Dr. Guy E. Noble, of St. Marys, at a recent meeting of the Maumee Valley Chapter, Ohio Society of Professional Engineers.

London—Dr. W. H. Lee of Plain City was elected president of the Madison County Board of Education at a recent organization meeting.

Lorain—"Mental Hygiene" was the subject discussed by Dr. Joseph M. DeNardi at a recent meeting of the Lorain Child Conservation League.

Madison—Dr. J. V. Winans was recently the guest of honor of the Madison Kiwanis Club. The occasion was Dr. Winans' entry into his 60th year of medical practice.

Mansfield—Dr. Paul A. Blackstone, of Bellville, was elected to a five-year term on the Richland County Health Board.

Marengo—Dr. William Ezra DeVol planned to leave early in April to return to China where he will join the staff of the University Hospital in Nanking. He was in the Orient from 1940 to 1942.

Millersburg—Dr. N. P. Stauffer was re-elected president of the Holmes County Board of Health.

Mt. Victory—Dr. G. Frederick Moench, who formerly practiced medicine in Mt. Victory, and was in health department work in Delaware, resigned his position with the Hillsdale County Health Department, Hillsdale, Mich., to accept a position as director of the Health Division, Atomic Energy Commission, Oak Ridge, Tenn.

New London—Dr. C. B. Meuser, of Ashland, Ashland County Public Health Commissioner, described the work of his department at a recent meeting of the New London Rotary Club.

Pomeroy—The clinic formerly owned by Dr. S. G. Martt was sold recently to the following physicians: Drs. S. J. Blazewicz, Raymond E. Boice, F. M. Cluff, Joseph J. Davis, William H. Jeric, and Charles J. Mullen. The new owners plan to enlarge the clinic from 12 to 20 beds.

Ravenna—"National Defense" was the subject of an address given before the Ravenna Rotary Club recently by Dr. Theo E. Tetreault, of Kent, former Army medical corps officer.

Sandusky—Dr. James D. Parker was re-elected president of the Sandusky City Board of Education in January.

Shelby—Dr. Charles L. Shafer, of Mansfield, spoke at the January meeting of the Shelby Federation of Child Conservation Leagues.

Springfield—Dr. A. K. Howell was elected president of the Springfield Country Club Co. in January.

St. Clairsville—Dr. C. V. Porterfield was re-elected to another five-year term on the Belmont County Board of Health.

Toledo—The American Academy of General Practice of Lucas County elected Dr. George H. Lemon president at a recent organization meeting. Other officers are Drs. Crawford L. Felker, vice-president; E. F. Ward, Jr., secretary; and Alex N. Johns, treasurer.

Toledo—Dr. E. Benjamin Gillette was elected chief of the Robinwood Hospital medical staff early in January, to succeed Dr. H. L. Green who had been chief of staff 26 years. Dr. Robert Gillette, brother of the new chief, retired as secretary and Dr. H. E. Smith was named his successor.

Troy—Dr. E. R. Torrence was speaker at a recent meeting of the Lions Club and told of experiences and observations in the Pacific as a member of the Army Medical Corps during the war.

Youngstown—Speaker for the January 21 meeting of the Youngstown Society of Medical Technicians in the Youngstown Hospital was Dr. H. E. Hathhorn. His subject was, "Laboratory Procedures of Importance to the Medical Internist in His Office."

Youngstown—At a January luncheon meeting of the Optimists' Club, Dr. Oscar Turner discussed the history and development of surgery of the nervous system. A lieutenant-colonel in the Medical Corps during World War II, Dr. Turner served in the European theater.

Youngstown—New officers of the Youngstown Eye, Ear, Nose and Throat Society are: Dr. William H. Evans, president; Dr. John S. Goldcamp, vice-president; and Dr. Virgil C. Hart, re-elected secretary and treasurer.

Coroners To Hold Seminar in Cincinnati, May 12-13

The Ohio State Coroners' Association will hold a seminar May 12 and 13 at the Hotel Gibson, Cincinnati.

Physicians who are not coroners or deputy coroners may attend as guests with no registration fee, Dr. Herbert P. Lyle, president, announced. Those wishing to attend are requested to communicate with Dr. Lyle at 912 Union Central Bldg., Cincinnati 2.

Features of the program for Wednesday, May 12, beginning at 9:30 a. m., are:

"Funeral Director, Coroner Relationship."

"The Code of the State of Ohio Governing the Conduct of the Coroner's Office," a round-table discussion with Dr. S. R. Gerber and Dr. Lyle as moderators.

"Toxicological and Related Chemical Examinations Conducted in the F. B. I. Laboratory, Washington, D. C.," by Briggs J. White, Ph. D., of Washington.

"The Coroner in Court," by Prosecuting Attorney Carson Hoy of Hamilton County.

The Thursday, May 13, program is as follows:

"The Medico-Legal Autopsy," by Dr. Mitchell A. Spyker, coroner of Franklin County, and an autopsy demonstration by Dr. Frank R. Dutra, pathologist to the coroner of Hamilton County.

"Anaesthetic Deaths," by Dr. Lloyd E. Larrick, Christ Hospital, Cincinnati.

"Operating Room Deaths," by Edward A. Gall, Cincinnati General Hospital.

Three Societies To Initiate Course April 13

The First Annual Postgraduate Day sponsored by Ashtabula, Lake, and Geauga County Medical Societies will be held on Tuesday, April 13, at Hotel Ashtabula, Ashtabula.

The afternoon program, beginning at 3 p. m., will consist of the following: "The Present Status of Treatment of Diseases of the Thyroid," by Dr. George Crile, Jr., Cleveland; and "Differential Diagnosis of Jaundice," by Dr. Harold R. Rossmiller, Cleveland.

The evening program will include an address on "Your State Medical Association," by Mr. George H. Saville, director of public relations of the Ohio State Medical Association; an address by Dr. Fred W. Dixon, Councilor, Fifth District, Ohio State Medical Association; "Diseases of the Colon," by Dr. Rossmiller; and "The Surgical Treatment of Peptic Ulcer," by Dr. Crile.

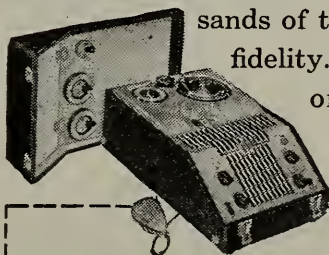
Cleveland—Officers elected by the Cleveland Society of Anesthesiologists are: Dr. Donald E. Hale, president; Dr. L. E. Campbell, vice-president; and Dr. R. M. Crane, secretary-treasurer.



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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

Volume 1, No. 1 of the *Butler County Medical Bulletin* was published for February by the Butler County Medical Society. At the regular February meeting of the society, Dr. Carl A. Wilzbach and Mr. Lou Herget gave a progress report on the cancer detection clinics.

CLINTON

The February meeting of the Clinton County Medical Society was held at the General Denver Hotel, Wilmington. Guest speaker was Dr. Lynne E. Baker, of Dayton, who spoke on "Tuberculosis."

HAMILTON

Dr. Joseph Earle Moore, of Johns Hopkins University School of Medicine, was guest speaker at a February meeting of the Academy of Medicine of Cincinnati. His subject was "Antibiotics in the Treatment of Venereal Diseases."

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

At the February scientific meeting of the Clark County Medical Society, Dr. Oscar F. Rosenow, of Columbus, spoke on "Diagnostic Points in Medicine."

DARKE

The Darke County Medical Society met on Feb. 17, when members heard a talk by Dr. T. P. Sharkey, of Dayton, on the subject, "Diabetes."

GREENE

Members of Greene County Medical Society heard an address by Dr. L. E. Reuscher, of Dayton, on "Digitalis—Uses and Limitations," on Feb. 5, in the County Courthouse, Xenia.

MIAMI

An illustrated talk on "Delayed Suture in the Management of Wounds," was given by Dr. K. F. Lowry at the March 5 meeting of the Miami County Medical Society at Stouder Hospital, Troy. Modern methods of diagnosis and treatment of epilepsy were discussed by Dr. Jerry Price, of New York City, at the Feb. 13 meeting of the Society.

MONTGOMERY

Dr. John A. Toomey, professor of clinical pediatrics and contagious diseases, Western Reserve University, was guest speaker for the Feb. 6 meeting of the Montgomery County Medical Society in the Van Cleve Hotel, Dayton. Guest speaker at the March 5 meeting was Dr. Leon

Schiff of Cincinnati. His subject was "The Differential Diagnosis of Jaundice." The meeting was held in the Engineers Club, Dayton.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D.,
UPPER SANDUSKY)

MARION

Ear, nose and throat problems in early childhood were discussed by Dr. Frederick Rea at the Feb. 10 meeting of the Marion County Academy of Medicine held at Hotel Harding, Marion.

SENECA

Members of the Seneca County Medical Society were addressed at their Feb. 10 meeting by Dr. R. Wenner Machamer, of Cleveland, on the subject, "The Care of Deafness."

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

LUCAS

The following program of the Academy of Medicine of Toledo and Lucas County for February was announced:

General Meeting, Feb. 6—"Roentgen Study in Pregnancies," by Dr. William Snow, Harlem and Bronx Hospitals, New York City.

Section on Pathology, Experimental Medicine and Bacteriology, Feb. 13—"Limitations and Indications for Surgery and Radiation Therapy for Cancer of the Breast," by Dr. U. V. Portmann, Cleveland.

Surgical Section, Feb. 27—"Progress in the Management of Thyroid Disease," by Dr. George M. Curtis, Ohio State University School of Medicine.

PUTNAM

Dr. Miles Flickinger, of Lima, addressed the Putnam County Medical Society on the subject, "Diseases of the Thyroid Gland," at a recent meeting.

WOOD

A paper on "Case Findings in Tuberculosis" was read by Dr. J. Howard Holmes, of Toledo, at the January meeting of the Wood County Medical Society in Perrysburg. At the Feb. 19 meeting, Dr. Howard J. Parkhurst, Toledo, presented a paper entitled "Diagnosis and Treatment of the Ten Most Common Skin Diseases." Speaker for the March 18 meeting was Dr. Max T. C. Schnitker, who spoke on "Headaches".

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

LAKE

The program of the Lake County Medical Society for Feb. 27 consisted of an address by Dr.

Frank M. Barry, Western Reserve University, on the subject, "The Treatment of Burns."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

MAHONING

"Some Observations on the Medical, Roentgen, and Legal Aspects of Silicosis," was the subject of a talk by Dr. Paul G. Bovard, roentgenologist of Allegheny Valley Hospital, Tarentum, Pa., before a February meeting of the Mahoning County Medical Society.

PORTAGE

Dr. Gerald B. Hurd, Cleveland, addressed members of the Portage County Medical Society, Feb. 5, on the subject, "Office Gynecology." Guest speaker at the March 5 meeting was Dr. George S. Phalen, of Cleveland, who spoke on "Treatment of Burns of the Hand." The meeting was held in Robinson Memorial Hospital, Ravenna.

TRUMBULL

Five Trumbull County physicians were honored at a joint meeting of the Trumbull County Medical Society and the Woman's Auxiliary for 50 or more years of service. They are: Drs. J. C. Henshow and S. S. MacKenzie of Warren, H. V. Ormerod of Niles, D. R. Williams of Girard, and B. G. McCurley of Cortland. Dr. Edward O. Harper, Western Reserve University School of Medicine, spoke on "Psychosomatic Medicine."

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

At the Feb. 19 meeting of the Belmont County Medical Society, Dr. Howard T. Phillips, Wheeling, W. Va., spoke on "Management of Early and Latent Syphilis." The meeting was at the Bellaire City Hospital.

TUSCARAWAS

"Defense Against Postoperative Embolism" was the topic of a talk by Dr. John A. Rogers of Youngstown, at the Feb. 12 meeting of the Tuscarawas County Medical Society, in New Philadelphia.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

GUERNSEY

Dr. Reo M. Swan was in charge of the February scientific program of the Guernsey County Medical Society. A film on intravenous anesthesia was shown.

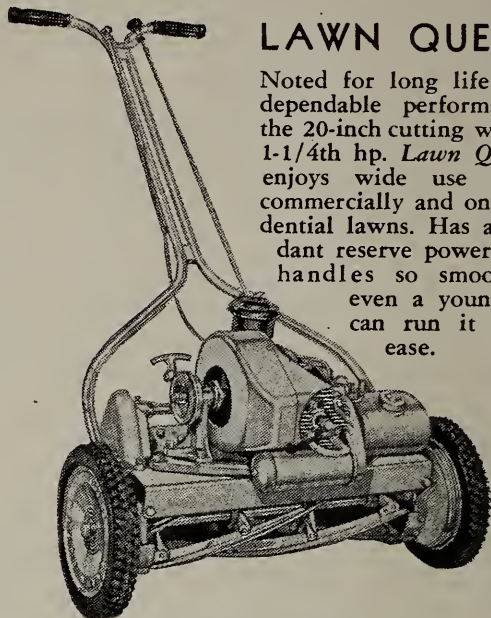
Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

GALLIA

The Gallia County Medical Society entertained about fifty physicians of surrounding counties on Feb. 26 at the Lafayette Hotel in Gallipolis. Drs.

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Edward J. McGrath and William F. Ashe of the University of Cincinnati Medical School, presented papers on "Medical and Surgical Aspects of Bronchial Diseases."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

"Clinical Investigation and Treatment of Peripheral Vascular Disease" was the subject of an address by Dr. William F. Bradley before the March 1 meeting of the Columbus Academy of Medicine. Dr. Kinsey M. Simonton, University of Minnesota School of Medicine, addressed the March 15 meeting on the subject, "The Symptoms of Dizziness."

ROSS

"Use of Wheat Germ Oil Concentrate in Pregnancy" was the topic of an address by Dr. Wynne M. Silbernagle, of Columbus, before the Ross County Academy of Medicine on Feb. 10. The Boy Scout summer camp immunization and examination program was approved.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

Guest speaker at the Feb. 10 meeting of the Lorain County Medical Society was Dr. John P. Anderson, Cleveland, who gave a talk on "Coronary Artery Disease." The meeting was held at the Spring Valley Country Club, Elyria. "Treatment of Some Common Skin Diseases," was the topic of a talk by Dr. Clyde L. Cummer, Cleveland, at the March 9 meeting.

Woman's Auxiliary News

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

ALLEN

The Woman's Auxiliary to the Academy of Medicine of Lima and Allen County sponsored a card party in the nurses' home at Memorial Hospital in February. Proceeds from the benefit will be used to establish a loan scholarship fund for a three-year nurses' training course in St. Rita's or Memorial Hospitals.

ASHTABULA

Discussing child psychology, Mrs. Joseph Miller was guest speaker at the dinner meeting of the Woman's Auxiliary to Ashtabula County Medical Society at Hotel Ashtabula. Dr. Fred W. Dixon of Cleveland, Ohio State Medical Association's Fifth District Councilor, spoke briefly. Mrs. Gerard DeOreo, wife of the speaker for the men's meeting, was a guest of the Auxiliary.

CLARK

Highlighting activities of the nurses' recruitment committee of the Woman's Auxiliary to the

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Clark County Medical Society was a meeting held on February 12 in the nurses' residence of the Springfield City Hospital.

Mrs. Edna W. Viets, R.N., president of Ohio State Nurses' Association, was the principal speaker. Her subject was "Trends in Nursing." Mrs. Elizabeth P. August, R.N., of Columbus, executive secretary of the Ohio State Nurses' Association, and Miss Mabel Ganger, director of the School of Nursing at the City Hospital, were guests. On February 26 the Auxiliary sponsored two nurses' benefit card parties during the afternoon and evening.

CUYAHOGA

The Woman's Auxiliary to the Academy of Medicine of Cleveland held its Winter luncheon meeting on Thursday, February 19, at the Skating Club. Mrs. A. B. Bruner presided. The program featured Dr. David M. Keating who spoke on "The Present Status of Medical Legislation." Mrs. Alexander T. Bunts and Mrs. A. V. Boysen were in charge of arrangements for the meeting. The local auxiliary, representing Greater Cleveland and Cuyahoga County, named its delegates to the Convention in Cincinnati as follows: Mrs. A. B. Bruner, Mrs. S. C. Lind, Mrs. R. A. Scherz, delegates; Mrs. F. T. Gallagher, Mrs. D. M. Keating, and Mrs. J. T. Ledman, alternates.

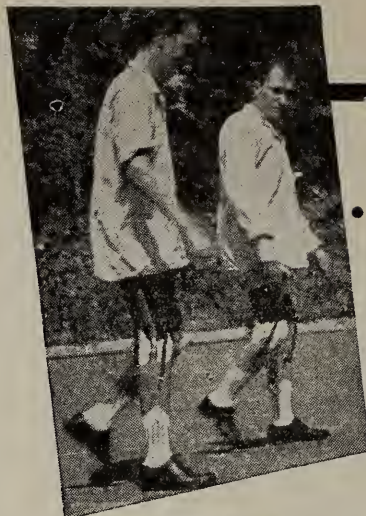
DARKE

Members of the Woman's Auxiliary to the Darke County Medical Society met at the Culmor Tea Room, Greenville, January 20, for lunch after which they assembled at the home of Mrs. Westbrook Browne. A business session was held with Mrs. J. E. Gillette, president, presiding. The Auxiliary has twenty-four members.

FAIRFIELD

Members of the Auxiliary to the Fairfield County Medical Society met at the home of Mrs. William D. Monger, Lancaster, for the January meeting. Mrs. G. S. Rodabaugh, Basil, president, presided at the business meeting, and introduced Mrs. Daisy Kumler of Basil, who brought to the meeting 25 tea pots from her extensive collection. Mrs. Kumler told the story of how and where she found her treasures, the use of tea from the very early days, and much of interest connected with its use as a beverage in the home and on ceremonial occasions.

Members of the Fairfield County Medical Society Auxiliary were invited to the home of Mrs. G. S. Rodabaugh, Basil, for the February meeting. During the business session conducted by the president, Mrs. Rodabaugh, the group voted to buy a table for the Cancer Clinic, also vote a subscription to *Hygeia* for the Clinic. During the social hour a unique music contest



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was presented by a guest artist, Mrs. George Weatherman of Basil.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine met on January 19 at the home of Mrs. Henry Schwarzell, Columbus. Mrs. Robert W. Kropp was chairman of hostesses. Mr. Juan DeCirota discussed the subject, "Furs—From Animal to Fashion".

GUERNSEY

The Woman's Auxiliary to the Guernsey County Medical Society met January 8 for the regular monthly meeting at the Maner Tea Room, Cambridge. Following the luncheon, the president, Mrs. J. A. Toland, presided at the business meeting. This was followed by a trip through the Cambridge Glass Company.

The Woman's Auxiliary to the Guernsey County Medical Society met for a luncheon meeting March 4 at the Berwick Hotel. After luncheon, Miss Margaret Brown, county social worker, gave a talk on "Juvenile Delinquency."

During the business session, the Auxiliary voted to give five dollars to Red Cross and also the fund for Crippled Children.

HARDIN

The Woman's Auxiliary to the Hardin County Medical Society met recently for a dinner at the Sunset Supper Club, Kenton, followed by a business meeting in the home of Mrs. S. P. Churchill. Each Auxiliary member contributed six gifts, to be distributed to residents of the County Home.

McKitrick Hospital served dinner to the Woman's Auxiliary to the Hardin County Medical Society. Superintendent Paul Moser of the Hospital spoke to the group and explained the plans and construction of the new Memorial Hospital building. A white elephant sale was conducted and the proceeds turned over to the general fund.

HIGHLAND

The Woman's Auxiliary to the Highland County Medical Society met February 4 for a luncheon meeting in Hillsboro. Mrs. W. M. Hoyt presided at the business meeting. Mrs. Mortimer Herzberg was the speaker for the afternoon. She told of her home in England, the home life of her people, and her coming to America.

LICKING

Covers were placed for thirty members of the Auxiliary to the Licking County Medical Society at the dinner on January 27 at Hull Place, Newark. Mrs. C. L. Petersilge was received as a new member and three guests were present including Mrs. Dwight Palmer of Columbus, Mrs. O. G. Houch, Cleveland, and Mrs. Louis

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TOLEDO, OHIO

Tilton of Frazeyburg. During the business meeting delegates were elected to the convention being held in Cincinnati. Mrs. George Gressle was named delegate and Mrs. Gilbert Mannino, as alternate.

LUCAS

Aid of the Academy of Medicine of Toledo and Lucas County Auxiliary in the drive for student nurses, sponsored by the Toledo Hospital Council, was pledged at a meeting of the Auxiliary's nurse recruitment committee with Mr. Wilson L. Benfer, chairman of the Council's student recruitment committee. Mr. Benfer explained that the committee plans to contact one hundred Toledo area high schools and conduct a publicity campaign through direct mail, newspapers, and radio. A graduate nurse will visit schools. Tentative plans for a nurses' training scholarship were discussed.

Dr. Willis F. Peck, Toledo radiologist, spoke on "The Use of Atomic Energy in Medicine" and gave a chalk talk at the meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County. The group toured the Libbey Glass Company on February 25. The Toledo Medical Library had its "face lifted," and auxiliary members voted to appropriate three hundred dollars to this Auxiliary project.

OTTAWA

Nine members of the Woman's Auxiliary to the Ottawa County Medical Association attended the meeting held at the home of Dr. and Mrs. George Poe. The achievements of the point system, which was sent out by the state auxiliary were discussed. The doctors joined their wives for refreshments and a social hour.

The Woman's Auxiliary to the Ottawa County Medical Society met at the home of Dr. Harriet Howes for its February meeting. Nine of the ten members were present. During the business meeting, the group decided to assist the committee for Cancer Control by locating sick-room equipment for loan to those needing it—

the loan of such articles to be rent-free. A letter from Mrs. E. B. Gillette of congratulation on the Constitution was read. The program for the evening was "Medical Organization and Function," and a study of the Constitution of the American Medical Association.

PICKAWAY

The Woman's Auxiliary to the Pickaway County Medical Society met at the Pickaway Arms Hotel, Circleville, on January 20 for a luncheon meeting. Plans and projects for the coming year were discussed. Election of officers followed: Mrs. Lloyd Jonnes, pres.; Mrs. Edwin Shane, vice-pres.; and Mrs. J. M. Hedges, secy.-treas.

Members of the Woman's Auxiliary to the Pickaway County Medical Society started their new year with a luncheon meeting in the Pickaway Arms. Mrs. Lloyd Jonnes, newly elected president, conducted the business meeting. Mrs. E. L. Montgomery, chairman, listed the programs for the year. Mrs. George R. Gardner of Ashville was appointed delegate to the State Convention in Cincinnati.

PREBLE

The doctors' wives of Preble County met recently to consider formation of a Woman's Auxiliary to the Preble County Medical Society.

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Guest speakers were: Mrs. E. B. Gillette, State chairman of organization, and Mrs. Harold K. Mouser, State president. It was voted to form an auxiliary and Mrs. E. P. Trittschuh, Lewisburg, was elected president; Mrs. B. R. Smith, Lewisburg, vice-president; and Mrs. J. R. Williams, Eaton, secretary-treasurer. Mrs. C. E. McKinley, Mrs. Von B. Barnhiser, and Mrs. James I. Nisbet were named on the Constitution committee by the president.

ROSS

Mrs. Holmes Iden reviewed "The Land of Promise" by Walter Havinghurst at the dinner meeting of the Woman's Auxiliary to the Ross County Academy of Medicine, at Highland's Dining Room, Chillicothe. The Auxiliary now has twenty-seven members. Mrs. Edwin H. Artman was elected delegate to the State Convention in Cincinnati and Mrs. F. W. Nusbaum was elected alternate.

The March dinner meeting of the Woman's Auxiliary to the Ross County Academy of Medicine was held March 4 at Highland's with eighteen members present. Mrs. John Franklin presided at the business session which followed dinner and appointed a nominating committee composed of Mrs. O. L. Iden, chairman, Mrs. H. M. Crumley, and Mrs. L. E. Hoyt. Plans were made for several members to attend the Ohio State Medical Association meeting to be held in Cincinnati.

TRUMBULL

The monthly meeting of the Woman's Auxiliary to the Trumbull County Medical Society was a luncheon meeting, January 16. After the business meeting, Dr. Eugene Elder of the Receiving Hospital in Youngstown gave a talk on "The Care and Treatment of the Mentally Ill".

The monthly meeting of the Woman's Auxiliary to the Trumbull County Medical Society was a joint dinner meeting with the Medical Society held February 19. After dinner, Dr. E. O. Harper, professor of neural psychiatry at the School of Medicine of Western Reserve University, gave a talk on "Psychosomatic Medicine."

TUSCARAWAS

The regular monthly meeting of the Woman's Auxiliary to the Tuscarawas County Medical Society was held at the home of Mrs. John Blinn, New Philadelphia. A large group was present to see the newly elected officers installed. Mrs. C. J. Miller, president, appointed her committees for the year. Letters from several of the county schools, thanking the Auxiliary for *Hygeia* subscriptions for the school, were read.

The regular monthly meeting of the Tuscarawas County Medical Auxiliary was held in Central High School, New Philadelphia, February 12. Three county schools sent thank-you notes for

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Surgery of Colon & Rectum, one week, starting Apr. 26, May 24. Surgical Pathology every two weeks.
UROLOGY—Intensive Course, two weeks, starting April 12.
FRACTURES AND TRAUMATIC SURGERY—Intensive Course, two weeks, starting June 7.
OPHTHALMOLOGY—Intensive Course, two weeks, starting May 10.
Ocular Fundus Diseases, one week, starting June 7.
GYNECOLOGY—Intensive Course, two weeks, starting April 26, June 7.
Vaginal Approach to Pelvic Surgery, one week, starting April 19, June 21.
OBSTETRICS—Intensive Course, two weeks, starting April 12, June 21.
MEDICINE—Intensive Course, two weeks, starting April 26.
Personal Course in Gastroscopy, two weeks, starting June 28, July 12.
Electrocardiography and Heart Disease, four weeks, starting May 3.
Hematology, one week, starting May 10.
Gastroenterology, two weeks, starting May 24.
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Hygeia subscriptions. Five members are planning to attend the Cincinnati luncheon.

UNION

The members of the Woman's Auxiliary to the Union County Medical Society entertained the doctors at a turkey dinner at the home of Dr. and Mrs. A. M. Johnston. A social program and evening followed the dinner. Nineteen members of the Society and Auxiliary were present for the get-together.

The Woman's Auxiliary to the Union County Medical Society held its monthly meeting on February 23. Following luncheon at the Dinner Bell in Marysville, members went to the home of Mrs. Albert M. Johnston on West Sixth Street for the program and business meeting, presided over by the president, Mrs. James Snider. From *The Ohio State Medical Journal*, Mrs. Johnston, program chairman, read an article on "The Ohio Medical Indemnity Plan."

WASHINGTON

The Woman's Auxiliary to the Washington County Medical Association at their dinner meeting held at the Betsey Mills Club, Marietta, had as their guest speaker, Mr. Glenn M. Smith, representing the American Red Cross.

Special Board Exams

The general oral and pathology examinations of the American Board of Obstetrics and Gynecology, Inc., (Part II) for all candidates will be conducted in Washington, D. C., May 16-22. Requests for information or application blanks may be addressed to Dr. Paul Titus, secretary, 1015 Highland Bldg., Pittsburgh 6, Pa.

The Board of Examiners of the American College of Chest Physicians will hold oral and written examinations for Fellowship in Chicago, June 17. Candidates should write to the Executive Secretary, 500 N. Dearborn St., Chicago 10. The 14th Annual Meeting of the College will be held at the Congress Hotel, Chicago, June 17-20.

Dr. Friedell Appointed on Isotope Committee


Included on the new Advisory Committee on Isotope Distribution, recently appointed by the Atomic Energy Commission, is Dr. Hymer I. Friedell, of Western Reserve University, Cleveland. The committee will recommend to the commission new policies governing the distribution of isotopes, will review existing policies and will act as adviser to the Isotopes Division of the Atomic Energy Commission on allocation of isotopic materials. Dr. Friedell also was named to a Sub-Committee on Human Applications.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Workmen's Compensation Insurance—Monopoly or Free Competition?

SOCIAL insurance is demanding increasing attention. It is the basis of Marxism's attempt to completely socialize the capitalistic countries. Unfortunately, the whole idea was borrowed from Germany where Bismarck attempted to use it as an opiate for labor, and brought to this country. It has been adopted without modification—when it might have been wise to ask, "Isn't there an American way of accomplishing the desired objective?" Our so-called "social security" program represents a two-edged sword. On the one edge, it is a form of double taxation for the working man to support a spend-thrift Federal government; on the other edge, it is a scheme to break down the Union of our states and Federalize all of our activities and in this way to so dry up the sources of "risk capital" as to lead to totalitarianism.

For 35 years, however, Workmen's Compensation has been proving an efficient, practical demonstration in this country of one form of social insurance administered under both public and private systems to give us a chance to work out the problem within the framework of our constitution. An examination such as is made in the book *Workmen's Compensation Insurance—Monopoly or Free Competition?*, by Frank Lang, Division of Research, Association of Casualty and Surety Executives. (\$4.00. Richard D. Irwin, Inc., Chicago) can, therefore, help to bring about a better understanding of many of the large social problems confronting us today.

COMPANIES SURVEYED

The files of 66 stock casualty companies and those of other large insurance companies were surveyed for data. Then, the unbiased opinions of state compensation administrators were obtained through personal visitation and interviews. Next, a study of the records of the procedures in the monopolistic fund states. Finally, personal visits were made to the two largest monopolistic funds—Ohio and West Virginia.

There has been a steady improvement in the over-all benefits to the injured workmen both in private carrier and competitive fund states, Dr. Lang concludes, and also a sharp decrease in the cost to employers for their compensation insurance. Reduced costs really mean reduced

losses. Behind these are safety statistics: Fewer deaths; fewer and less severe accidents and occupational disease; more workers quickly restored to health; more workers effectively rehabilitated. While the difference between fair and superior medical service cannot be shown by a diagram, a study of the comparison over the years tells of its improvement.

FATALITIES HIGH

We in Ohio are deeply concerned with the indictment that the industrial safety work of the fund is inadequate as evidenced by the record, the amount of money expended, and the presence of some twenty or thirty service organizations which for a fee, conduct safety inspections and make recommendations as a service to their clients. Ohio's record of industrial fatalities is exceptionally bad and is well over twice that of each of the following: New York, Michigan, Indiana, or Illinois.

On the other hand, Ohio's rating system is according to this report more orderly, scientific, and comprehensive than that of any other monopolistic state fund. Unfortunately, however, its very comprehensive system is much hampered by the ineffectiveness of its payroll auditing.

As has been pointed out by many investigators, the cost of workmen's compensation insurance to the larger Ohio employers is not limited to their premium since they are obliged to engage the services of service organizations to help them in accident prevention, checking upon merit rating, and processing the settlement of claims. These service operators contract with the employer on a fee basis (from 5 to 25 per cent of the original premium). These organizations service about 1500 accounts—involving about 25 per cent of the total premium income of the fund. Ohio, however, is not alone in this matter. Other states have such organizations as well.

BURDEN ON CONTRIBUTOR

Authorities are usually against the public bearing the operating cost, insisting it should be borne by the contributor with certain established limitations. It seems to us, however, that the fund should pay its personnel properly and obtain other badly needed technical and clerical

personnel, thereby improving the general efficiency of its organization.

Lang's conclusions might be summarized by the quotation which he makes from Marshall Dawson's book on Workmen's Compensation Administration.

HANDICAPS

"The main handicaps of the Ohio Fund . . . are (1) Dependence upon legislative appropriation for administrative support; (2) a complicated claims procedure, due largely to the predisposition of groups in Ohio for legal technicalities, and latitude as to court appeals; (3) salaries for commissioners and technicians inadequate for a fund of such magnitude; and (4) political turn-over of commissioners. All the exclusive state funds have suffered from one or all of these handicaps."

Of course, they arise from a traditional attitude with regard to public employment. Funds of the size of that of Ohio should, it would seem, be free to borrow more from the experience of private casualty companies in efficiency. Better still, Lang suggests they be put in direct competition with them. Certain it is that the commissioners should have more time to administer, should get larger salaries, and be permitted to turn the hearings over to trained personnel.

* * *

A Textbook of Clinical Neurology, by Israel S. Wechsler, M.D. (\$8.50. Sixth Edition. *W. B. Saunders Company, Philadelphia*) has been one of the leading texts in the field for twenty years. Emphasis is placed on the anatomy of the brain as a prerequisite to an understanding of its function.

Health and Rehabilitation Through Chest Training, by Samuel Delano, M.D., (\$2.50. *William-Frederick Press, New York City*) is based upon the solid conviction that exercise is a short cut to health. Its author is not a cultist but a sound physician with a great many years of clinical experiences. This is not muscle building gymnastics. The fact that the author is strong and robust as he approaches his eighty-ninth birthday lends added proof to the value of his system. The book belongs in the library of every physician who treats asthma, bronchiectasis, or tuberculosis.

Calcium and Phosphorus in Foods and Nutrition, by Henry C. Sherman, (\$2.75. *Columbia University Press, Morningside Heights, New York*) is a book that every one dealing with disease and health should own and study. The findings set forth by this great authority, can thus become of great service to the war-torn world with its soil depletion.

Synopsis of Neuropsychiatry, by Lowell S. Selling, M.D., (\$6.50. Second Edition. *C. V.*

Mosby Company, St. Louis, Missouri) will continue to serve as a simplified systematic coverage of the field. Furthermore, it furnishes the student systems with which to organize his thinking and supply his memory with basic facts.

What You Can Do for High Blood Pressure, by Peter J. Steincrohn, M.D., (\$2.50. *Doubleday & Co., Inc., Garden City, New York*) tells what is known but does not fill in the gaps with a single word that might throw the truth out of focus. Your reporter has always made ready use of such books in the education of his patients, believing that they are always entitled to know the whole truth.

The American Farmer: His Problems and His Prospects, by Lee Fryer with a foreword by James G. Patton, president, National Farmers Union, (\$3.00. *Harper & Brothers, New York City*) deals with the problem of relating the science and business of agriculture to the lives of those on the farm. In forming a new long-range land-use policy, the Congress must take into account not only the restoration and conservation of the soil, but the hard-working mother and her children in relation to housing, needless miscarriages, tuberculosis, and toothaches, when providing for rural sickness. We must provide for the 30,000,000 people who produce the food and fiber for themselves and for the rest of the other 110,000,000 citizens of the U. S. The author with the blessing of the Farmers Union, paints an accurate picture of the problems of rural sickness and then proceeds to treat symptoms. He does not seem to know about creative medicine which would keep the health of these people in the very best possible state, free of diseases without pills or operations. He demands and rightly so, preventive medicine for the farm folk to prevent sickness and accidents. He exhibits a childish faith in curative medicine which repairs but never restores. Every physician has a big stake in rural health and sickness. The proponents of the nationalization of medicine offer a socialistic philosophy to the country people, and it is the "farm vote" that accepts or rejects the destruction of modern medical practice for the rest of us.

Handbook of Fractures, by Duncan Eve, Jr., M.D., (\$5.00. *C. V. Mosby Company, St. Louis, Missouri*) represents the teachings at Vanderbilt and puts the emphasis on practical treatment.

Diseases of the Nose, Throat, and Ear, by Drs. W. L. H. C., and J. J. Ballenger, (\$12.50. Ninth Edition. *Lea & Febiger, Philadelphia*) brings this standard text up to date. There is a new chapter on Headaches and Neuralgia of the Face and Head.

Health and Fitness, by Florence L. Meredith, M.D., (\$2.20. *D. C. Heath & Company, Boston*)

is a book for high schools, as it intelligently gives primary attention to what students want to know and with plenty of sugar-coating of that which students ought to know. In this way, the author has produced a book which high school students will like to study.

The Book of Rosicruciae, by R. Swinburne Clymer, M.D., Supreme Grand Master, (\$3.00. *The Philosophical Publishing Company, Beverly Hall, Quakertown, Pennsylvania*) is a condensed History of the Fraternitas Rosae Crucis, or Rosey Cross, the men who made the Order possible, and those who maintained the Fraternity throughout the centuries together with the fundamental teachings of these men according to the records in the Archives of the Fraternity.

The Foot and Ankle, by Philip Lewin, M.D., (\$11.00. Third Edition Revised. *Lea & Febiger, Philadelphia*) tells of their injuries, diseases, deformities, and disabilities in 850 pages of text with 389 illustrations, mostly line drawings by Harold Laufman, M.D.

The 1947 Year Book of General Medicine, (\$3.75. *The Year Book Publishers, Chicago, Illinois*) presents approximately 785 pages into which has been crowded all that is worth while in the field in the past twelve months. Your reporter suggests that you take this book to bed and do about ten pages each night before you get sleepy.

The Treatment of Drug Addicts: A Critical Survey, by P. O. Wolff, M.D., Buenos Aires is Number 4 of Volume XII of the Bulletin of the World Health Organization of the United Nations from Geneva, Switzerland (apply).

My Polio Past, by Noreen Linduska, (\$2.75. *Pellegrini & Cudahy, Chicago*) tells in a simple effective fashion the encouraging story of one case.

Practical Child Guidance and Mental Hygiene, by Samuel Kahn, M.D., Grace Kirsten, and May Elish March, (\$4.00. *Meador Publishing Company, Boston*) is in question and answer form and is intended for parents, educators, social workers, physicians, lawyers, ministers, and institutional workers. It will make a valuable addition to the library of anyone interested in the development of individuals with good personality and fine character.

Hernia, by Leigh F. Watson, M.D., (\$13.50. 323 Illustrations. *C. V. Mosby, St. Louis, Missouri*), treats of the anatomy, causes, symptoms, differential diagnosis, prognosis, and treatment of this common condition. It now includes all of the many advances that have been made recently in the surgical treatment of hernia.

The "Have More" Plan, for a little land—a lot of living, by Ed and Carolyn Robinson, (\$3.49.

Macmillan Company, New York City) offers a cure for many an urban neurotic. Your reviewer often makes use of it and among his most grateful patients are those who have gone to a little place in the country to indulge themselves in raising their food as a hobby while their regular job becomes their "cash crop". No one can become or stay a psychoneurotic who creates with his hands. To get one's feet and hands in the soil brings one close to God and gives one a sense of security that no socialist scheme of governmental guardianship can ever give. In the meantime, if followed consistently, it creates real health, and sickness is no longer a problem. Try it if you will, Doctor, on some of your neurotics. You will be surprised. The Robinsons tell all.

Personality, A Biosocial Approach to Origins and Structure, by Gardner Murphy, (7.50. *Harper & Brothers Publishers, New York City*) offers much help to those of us who try to understand our patients. We try so hard to approach their problems through biology—the only way that we are trained to do—and to have this discussion of their personality also from a biosocial approach proves most helpful. This is the proper approach to the presently popular Psychosomatic Method.

1946 Year Book of Dermatology and Syphilology, edited by Marion B. Sulzberger, M.D., and Rudolf L. Baer, M.D., (\$3.75. *The Year Book Publishers, Inc., Chicago*) each proves to be one of the most valuable volumes in my personal library. For those of us who are now trained skin specialists, this book offers a real education. We always look forward to the special article at the beginning of each new volume.

This year it has to do with advances in dermatological advancement. As to the use of sulfonamides, the authors warn us against the external application of these drugs. As to the topical application of penicillin, they say the same thing. There is no justification of subjecting our patients to the dangers of these drugs in salves and ointments when we can accomplish just as much by the older orthodox local remedies. The authors then review the use of the quinolines, podophyllin, the new antiscabieties, BAL tar preparations, and the role of fatty acid in superficial fungi infections. The whole work is up to its usual high standard that I have come to expect of everything to which these authors turn their hands.

A Manual of Clinical Therapeutics: A Guide for Students and Practitioners, by Windsor C. Cutting, M.D., (\$5.00. Second Edition. *W. B. Saunders Company, Philadelphia*) gives the newer material on antibiotics and sulfonamides as well as the antihistamines, antithyroid drugs,

folic acid, and the new anti-convulsants. It makes a very workable manual.

Successful Marriage, edited by Morris Fishbein, M.D., and Ernest W. Burgess, Ph.D., (\$6.00. *Doubleday & Company, Garden City, New York*) is an authoritative guide to the problems related to marriage from the beginning of sexual attraction to the successful rearing of a family. It is a symposium done by some 47 authorities.

A Manual of Pharmacology, by Torald Sollman, M.D., (\$11.50. Seventh Edition. *W. B. Saunders Company, Philadelphia*) is a completely revision of the well-known text which has served American medical students for over thirty years. Its record speaks for the book itself.

Minor Surgery, by Frederick Christopher, M. D., (\$12.00. Sixth Edition. *W. B. Saunders Company, Philadelphia*) represents a sincere and successful effort to bring to the doctors who must of necessity take care of the majority of cases requiring minor surgery.

Nutrition and Physical Fitness, by L. Jean Bogert, Ph. D., (\$3.00. Fourth Edition. *W. B. Saunders Company, Philadelphia*) is a hand volume containing the facts useful in meeting everyday nutrition problems and how to use these facts to promote a high degree of health.

Medicine and Health in the Soviet Union, by Henry E. Sigerist, M. D., (\$4.00. *The Citadel Press, New York City*) gives in detail the advances that have been made in the modernizing of these peoples. In 1937, the author gave us an outline of the plan of organization of Soviet medicine in his **Socialized Medicine in the Soviet Union** in which he became enthusiastic about the plan, its objects, and its preliminary accomplishments. Now, in this volume, after five years of investigation and personal inspection, the author has given us a report of the developments that have taken place in the meantime.

To the author this is a happy outcome. To the reviewer, it is convincing evidence that by maintaining its former birth rate in the U.S.S.R., and introducing the sanitation, preventive, and curative medicine, means that there will be 11,500,000 Russians in the world and there will be no room for anyone whose ideas differ. Their numbers will compel them, if their ideas do not, to take the world like grasshoppers take a Kansas wheat field in a dry year.

Stop Annoying Your Children, by W. W. Bauer, M. D., (\$2.75. *The Bobbs-Merrill Company, Indianapolis, Indiana*) is the answer of the Director of the Bureau of Health Education of the A.M.A. to the problem of raising children with as little wear and tear on the parents as possible.

The Practice of Group Therapy, edited by S. R. Slavson, (\$5.00. *International Universities Press,*

New York City) is basically a special application of the principles of individual treatment to two or more persons simultaneously which also brings into the situation the phenomena and problems of interpersonal relationships.

The Impact of a Children's Story on Mothers and Children, by Martha Wolfenstein, Monograph of the Society for Research in Child Development, Series 42, Vol. XI, Issue No. 1, (*National Research Council, Washington 25, D. C.*) is a study of this problem. The story which deals with the birth of a second child in the family functions as a projective technique for eliciting feelings of mothers and children about this event. To me the most interesting reaction was the belief of mothers in the omnipotence and unlimited responsibility. We need more studies like this to teach what people are really like.

Outline of Anthropology, by Merville Jacobs and B. J. Stein, (\$1.25 paper. *Barnes & Noble, Inc., New York City*) presents the subject as a mature science with all of its humanistic appeal. Well worth any physician's time even though it is intended as a college text.

Happiness for Patients, by Rev. John Joseph Croke, (\$2.00. Third Edition. *Catholic Book Publishing Company, New York City*) should prove of invaluable assistance in the cultivating of a normal sensible attitude toward their affliction, especially on the part of the chronically ill—those living crucifixes we meet upon the highway of life.

How Life Is Handed On, by Cyril Bibby, (\$2.00. *Emerson Books, Inc., New York City*) tells in a sparkling but very simple style what is known about reproduction (literally), inheritance, and our declining birth rate.

Micro-Analysis in Medical Biochemistry, by E. J. King, Ph. D., (\$3.00. *Grune & Stratton, Inc., New York City*) is a small but comprehensive manual written in an understandable style by an English professor of chemical pathology.

Diabetes Mellitus in General Practice, by Arthur R. Colwell, M. D., (\$5.25. *The Year Book Publishers, Inc., Chicago, Illinois*) is a good summary written by the Director of Speciality Education at Northwestern Medical School. All who see patients will do well to read this excellently organized review.

A Textbook of Pathology, by William Boyd, M. D., (\$10.00. Fifth Edition. *Lea & Febiger, Philadelphia*) contains some fifty or more new sections and much revision of the older text. It remains one of the outstanding introductions to modern medicine.

Applied Medical Bacteriology, by Max S. Marshall, (\$4.50. *Lea & Febiger, Philadelphia*) is the joint effort of the University of California staff to present the aspects of this field of direct interest to physicians.

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Practical Surgical Points in Strabismus

M. PAUL MOTTO, M.D.

SURGERY of the extra ocular muscles is a significant and fascinating field of ophthalmology. The importance of surgical intervention to the individual who is afflicted with squint or a marked muscle disturbance cannot be overemphasized, because of the ultimate effect which an operation may have on the patient's social and economic status, and future happiness. Therefore, I feel that the time is profitably spent in occasionally reviewing some pertinent phases of the subject of strabismus in order that we may properly evaluate the more recent concepts relative to it.

HISTORY

Before any operative interference is resorted to, it is quite essential that a thorough history of the case be taken. The history should include heredity; a possible birth injury; and the age of the onset of the squint. Furthermore, it should include any observation such as the position of the head or any abnormal fixation.

COMPLETE MUSCLE SURVEY

It is highly desirable to follow a systematic routine examination, because by so doing, nothing of importance will be overlooked, and your results will be more satisfactory. Following is essentially the examination which I endeavor to adhere to as closely as circumstances will permit:

- (1) History.
- (2) Vision.
- (3) The measurement of the deviation at 6 meters and 33 centimeters.
- (4) The muscle movements in the six cardinal directions of the gaze.

Presented before the Section on Eye, Ear, Nose, and Throat at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6, 1947.

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- (5) The measurement of the deviation in each of these fields.
- (6) The near point of convergence.
- (7) The state of the fusion faculty.
- (8) Refraction under atropine.

PSYCHOLOGY

The psychology of the child afflicted with squint should always be considered. Such a child as he grows older, generally avoids company; is supersensitive; diffident; and extremely bashful. Later, he may be so affected that he dislikes school and his companions. He may acquire an inferiority complex and because of his failure to adjust himself to his environment, go through life quite unhappily. For this reason this child demands close attention, study, and guidance. There should be no delay in correcting his squint, to avoid an addition to the already large army of the maladjusted.

OPPORTUNE TIME TO OPERATE

Twenty-five years ago ophthalmologists postponed operating until the patient was twelve or fifteen years of age. This was an ultra conservative stand based on the opinion which prevailed

then that time would improve or correct the condition. However, in recent years a broader view of the favorable time to operate has been taken. Because of the danger of possible loss of vision in the deviating eye, and the probable maladjustment and psychological changes in the patient, most ophthalmic surgeons prefer to operate before the sixth year when the child enters school. This in my opinion is the best procedure and one which I feel produces better results.

The question as to when to operate is a most important one which cannot be answered before a diagnosis is made. Consideration should be given to the history and duration of the squint; information relative to the development, progress, and amount of deviation; the type of refractive error; the visual acuity; and the effect which lenses have on the deviation. When the degree of deviation is marked and the refractive error is slight, no time should be lost in correcting the deviation surgically. Certain it is that if there is a convergent squint of 40 degrees and the refraction shows a plus 1.00 diopter sphere to 1.50 diopter sphere, no improvement can be expected with the correction. Therefore, the sooner we operate the better, if we are to retain the vision in the deviating eye and at the same time obtain a cosmetic result. One may be forced to operate at the age of two or three years. White¹ operated successfully on a child twenty months old who had a convergence of 80 degrees. This type of case is rare, but it should be handled in the same manner. The youngest child operated by me was three years of age. I have also had a number that were four years of age, all of whom were improved. Therefore, the age should not worry us too much. It is certain that after a thorough investigation and individualization of the case, the problem will not be a difficult one.

POINTS TO BE CONSIDERED BEFORE OPERATING

The following are some points to be considered before resorting to operation and which may aid us in arriving at a decision as to the time when operative interference is called for:

- (1) The amount of hypermetropia.
- (2) The overacting interni.
- (3) The underacting external recti.
- (4) The amount and character of the near point of convergence.
- (5) Vertical deviation.

Due consideration will have to be given to the amount of hypermetropia, as noted above. Overacting interni in most cases will require a recession. Underacting externi will require a resection. When the near point of convergence is remote, care must be taken not to weaken the interni more, but attempt to get our result by attacking the externi. Vertical deviation, when

slight, should be operated before the lateral is attempted. However, when the lateral deviation is marked and overshadows the vertical, it is a wise procedure to correct the lateral squint first. In cases where there is a monocular convergent squint with low visual acuity, it is safer to undercorrect.

CHOICE OF ANESTHESIA

The anesthesia employed most frequently at the University Hospitals is ether, in children up to fifteen years of age. In those fifteen years and over, cocain 4 per cent instillation, and novocain 1 per cent infiltration of the muscles are used. This method of anesthesia has proven practical and safe and we have had no reason to change to the more recent type of intravenous anesthesia, except in exceptional cases when pentothal sodium has been used successfully.

SUTURE MATERIALS

In children, the suture material which I employ is 000 chromic cat gut with double armed atraumatic needles for the muscles, and plain silk No. 3 for the ocular conjunctival closure. The latter is a running suture, untied, and left with long ends to facilitate easy removal. In adults, I prefer to use silk throughout. The greatest objection to the use of cat gut is the marked reaction which occasionally follows its use and delays recovery.

OPERATIVE TECHNIQUES EMPLOYED

When we have made a decision that operative measures are necessary, we should select that operative technique which has proved through experience to be most effective in producing a favorable cosmetic and functional result.

The operative techniques which I have found to be most satisfactory are (1) the Jameson recession, where a decrease in the function of any muscle is required; (2) the resection, where an increase in the function of any of the recti is desired; (3) for paralysis of the superior rectus muscle, tenotomy, tenectomy, or recession of the inferior oblique muscle of the other eye.

Up to a few years ago my operative procedure in muscle surgery was that of the Reese resection, combined with the Jameson recession. At present I use a modified method of Meller of Vienna for the resection; and for the recession I do a modified Jameson.

Jameson² stated that the internus could be safely receded up to 5 millimeters, but the conservative distance he considered was 4 millimeters. I learned early that even a recession of 4 millimeters was too much, as the action of the internus was inhibited greatly, convergence weakened, and the patient complained of diplopia.

So today, I never recede more than 3 millimeters, and more often 2.5 millimeters; and have found this procedure more beneficial, with no bad results. The anchorage is done at a determined site on the sclera, and then the double armed suture is brought to the stump of the muscle where it is tied. This in my opinion is an added security. It is well to remember that when you are dealing with a weak internus that you be ultra conservative in the amount of recession. You may be forced to recede the internus of the opposite eye to obtain the desired effect.

Recession of the externus should never exceed 3 millimeters, because the anchorage would be at or beyond the equator, greatly limiting the action of the muscle and causing diplopia.

THE CORRECTION TO BE EXPECTED

The amount of correction from a recession alone or combined with a resection varies with different ophthalmic surgeons. Some have claimed a correction of 40 to 60 degrees. For a single recession of 3 to 4 millimeters, one can expect a correction of 20 to 25 degrees.

When doing a resection combined with a recession, it is always a good plan to operate first on the muscle which we desire to strengthen. The resection which I perform is a modification of the Meller in which the muscle is not advanced and only one double armed, whipped suture is employed; instead of two. For a wide resection one should expect an improvement of 25 to 35 degrees.

INFERIOR OBLIQUE OVERACTION

When there is a moderate overaction of the inferior oblique and the amount of hyperphoria is 7 to 12 degrees, I prefer to do a simple tenotomy, as this procedure will correct all or practically all of the overaction. When the amount of hyperphoria is 15 degrees or up, tenectomy is in order. A resection of 5 to 8 millimeters of the muscle will give a correction of 15 to 20 degrees.

The recession of the oblique has been practiced in the United States for the past ten years with varying degrees of success. White,³ who initiated the operation, claimed that it is the procedure of choice. However, able ophthalmic surgeons who have given the operation a fair trial, do not feel that it is a reliable procedure because of the inconsistent results. Certain it is that the reaction in this operation is out of all proportion to the trauma. Personally, I have performed the operation several times and while I have had fairly good results, I can see no advantage in it.

POSTOPERATIVE CARE (RESECTION AND RECESSION)

Upon completion of the operation, both eyes are bandaged for twenty-four hours follow-

ing which only the operated eye is padded. The first dressing is made, consisting of boric-saline flush; atropine 1 per cent, if necessary; and bichloride ointment, 1-3000. This routine is adhered to for five days, after which both eyes are left uncovered and dark glasses prescribed for outdoor use. The treatment at home consists of hot compresses for a ten-minute period, three times a day, followed by zinc sulphate, 1/4 per cent, two drops three times a day; and penicillin calcium ointment, 250 units per gm., used at bedtime. Sulfathiazole 5 per cent, or bichloride ointment, 1-3000, also may be used at the discretion of the ophthalmologist.

Marked reactions from the cat gut call for ice compresses or an ice bag, twenty minutes, three times a day. Occasionally a case will be encountered which will require some form of foreign protein. This treatment can be continued for twenty-four hours, when the routine suggested above can be instituted. As a rule, the operated eye will have returned to practically normal in a month when silk is used. However, due to cat gut reactions, there will be in most cases a moderate swelling at the site of the resection which gradually recedes, so that the period when the eye returns to a normal state may be six or eight weeks.

POSTOPERATIVE REFRACTION

Several months after the operation it is advisable to do a complete refraction, or when a preoperative cycloplegic refraction has been done, to resort to a postcycloplegic test. It will be found frequently that a marked disparity exists between the preoperative and the postoperative refraction and the patient should be given the correction with which he will be comfortable. The prescription should be reduced in amount when you have had a marked reduction in the deviation following the operation.

FACTORS INFLUENCING AMOUNT OF CORRECTION

It is difficult to make a definite statement as to the amount of correction that can be made, as so many factors alter the case and each should be considered on its merits. These are: The amount of deviation; the duration of the squint; the percentage of vision in the operative eye; the strength and condition of the muscle; the points of insertion; and the extent of the adhesions surrounding the muscle. These reasons make it impossible to lay down any set rules for strengthening or weakening a muscle. So-called perfection can only come from constant study, observation, and years of experience with many and various types of squint. The theory that one obtains 5 degrees of correction for every millimeter of recession or resection of a muscle is not true. It would be more nearly correct to state that one obtains 2.5 to 3 de-

degrees of correction for every millimeter of recession or resection of a muscle.

SOME CAUSES OF FAILURE

Failures may be attributed to various causes; for example, an overactive inferior oblique spasm will effect the operative result unfavorably. Failure to recognize a two-bellied inferior oblique muscle will lead to an unsatisfactory outcome. A too-wide resection will also make for a poor result, causing an original convergence to become a divergence. This, however, is an error of judgment and can be corrected by undercorrecting nasal deviations until such time as the surgeon becomes more conversant and proficient with muscle surgery. Poor anchorage or too wide a recession will lead to an unsatisfactory result; as will low visual acuity of less than 6/60 with or without macular changes. The experience of most ophthalmic surgeons is that they obtain fair or poor results in divergent cases. This has been my experience. The cause for this has never been satisfactorily explained.

FAVORABLE RESULTS

Most ophthalmic surgeons report favorable results in dealing with the vertical and convergent deviations. If our cases are studied properly, thoroughly surveyed and individualized, it is not an exaggeration to state that there will be an improvement or complete correction by surgery in 95 to 97 per cent of these cases.

SUMMARY

In this review of the practical surgical points in strabismus, I have endeavored to stress the importance of a thorough history and the value of a complete muscle survey. The psychology of the child afflicted with squint is brought out, and the possible danger of the patient acquiring an inferiority complex is pointed out.

The opportune time to operate and the points to be considered before resorting to operative interference are reviewed. The choice of anesthesia and suture material are briefly discussed.

The various operative techniques and post-operative care are touched on and what results are to be expected. The causes of failure are indicated, and the methods of reducing these unsatisfactory results are given.

Attention is called to the fact that all operative cases should have a complete refraction in a reasonable time following the operation.

CONCLUSION

In conclusion, I would like to reiterate that the early recognition and treatment of squint cases should be stressed and advocated. Valuable aid in this direction can be given by the general practitioner and pediatrician who observe these

patients first. The laity should be warned of the danger of procrastination and against placing too much reliance on the old popular belief that "a child will outgrow the crossed eye".

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Present Trends in Gastric Surgery

Modern advances in the therapy of gastric carcinoma have been along the following lines:

1. Need for extended careful preoperative preparation.
2. The liberal use of whole blood before, during, and after operation.
3. The need for radical resections with meticulous removal of the great omentum and all associated lymph nodes, especially at the origin of the left gastric artery.
4. Radical resections of carcinoma of the upper end of the stomach by the use of a combined abdominothoracic incision with intra-thoracic esophagogastric anastomosis. This has been one of the great recent advances in gastric surgery.
5. The more extended use of the operation of total gastrectomy. In order to greatly simplify this operation I recommended over a year ago the combined abdominothoracic approach and the use of the Y anastomosis between esophagus and jejunum after the principle of Roux. The combined incision permits of accurate visualization of the entire field of operation, thereby assuring a radical lymph node dissection, and the Y anastomosis produces, in effect, a pouch of jejunum to act as a stomach and to minimize considerably the digestive disturbances usually seen after the ordinary loop esophagojejunostomy.

I now have a not inconsiderable number of five-year and over survivors following radical stomach operations for cancer. As time goes on this number is apparently increasing, although not as rapidly as one would wish. Future improvement in results will depend in large part on the diagnostic acumen of the practicing physician and the speed with which he refers his patients for competent surgical therapy.—John H. Garlock, M. D., Medical Annals of the District of Columbia, Vol. XVII, No. 3, March, 1948.

Meniere's Disease

WILLIAM C. THORNELL, M.D.

IN 1861, Ménière¹ first described the triad of symptoms vertigo, tinnitus, and deafness, now known as Ménière's disease. Although the syndrome which he described is now definitely established as a clinical entity, the pathological report of one of the cases he originally described was undoubtedly one of acute labyrinthitis or leukemia. Since his description of this syndrome appeared, many theories as to etiology have been advanced. The majority of observers now accept the theory that increased endolymphatic pressure or so-called endolymphatic hydrops, rather than hemorrhage, is the causative factor. This is produced by either an increased production of endolymph from the stria vascularis or decreased absorption. Recent trends of thought are borne out in the pathological studies made since 1938.² In all of the cases, dilatation of the endolymphatic system was present, which indicated an increased endolymphatic pressure. There was no evidence of inflammation in any of these cases. Lindsay³ suggests that the production of the vertigo results from herniation of the utricular wall into the ampulla producing a distortion of the ampulla and thus interfering with the normal function of the cupula ampullaris. The auditory symptoms he explained on a physical or mechanical basis, an interference in the transmission of sound in the cochlear fluid being the result of the distorted saccule, Reissner's membrane, and a disproportion of both the scala media and scala vestibuli.

Mygind and Dederding have attributed this increase in endolymphatic fluid to a disturbed water metabolism, while Furstenberg, Lashmet, and Lathrop contend that retention of electrolytes, chiefly sodium, and not the accumulation of water alone was the cause for this syndrome. H. L. Williams⁴ believes that Ménière's disease may be regarded as a physical or intrinsic allergy, in so far as it involves the inner ear. Alteration of the capillary permeability by histamine or a histamine-like substance producing either an intracellular or extracellular edema was suggested by Sheldon and Horton in 1940.

SYMPTOMS

Any one of the symptoms of vertigo, tinnitus, or deafness may occur first. The vertigo is paroxysmal in nature and may occur any time of the day or night. It is very important to obtain a careful history of the patient's sensation, rather than to accept the term "dizziness". Labyrinthine vertigo is described as a sense of

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whirling, spinning, or rotation, or a sensation that the outside surroundings are spinning around, or that objects are moving to one side or the other. It is frequently accompanied by nausea or vomiting. Many times it is followed by severe headache.

The tinnitus may be paroxysmal or constant and may vary in intensity and pitch. This may be the first symptom noted. It is usually unilateral, but when bilateral, it is usually more pronounced in the involved ear. It is usually steady in character rather than pulsating. If tinnitus is constant, the patient will notice that the tinnitus is markedly increased, or changes somewhat in character immediately preceding, during, or following the episode of vertigo.

Loss of hearing may occur early or late in the disease and is usually unilateral in the majority of cases. Audiometric studies reveal the hearing loss to be of the nerve type of deafness but in an occasional case, a conduction type of deafness has been noted. Diplacusis is present in most cases, and in several musicians that I have seen, this was a most distressing symptom. It is quite common for the hearing to vary from time to time, making it quite difficult for a patient to adjust himself to a hearing aid when the deafness is bilateral.

The above triad of symptoms represent the true classical Ménière's disease. There are many borderline cases, in which the only complaint presented by the patient is "dizziness". This symptom should be carefully described in the patient's own words, without any leading questions. The most frequent condition which closely resembles Ménière's disease is postural vertigo. This condition is usually on a vascular basis. It is described by the patient as being momentary episodes of "dizziness" or of true vertigo, associated with sudden movements of the head,

Submitted August 13, 1947.

rising suddenly from a lying position, bending over or stooping over. This is thought by some observers to be but a stage of true Ménière's disease.

DIAGNOSIS

The diagnosis of Ménière's disease is mainly derived from the history and it is especially important in these cases to obtain a careful and complete history. It is necessary to rule out cerebellar pontine angle lesions which may be either vascular in nature or the result of an acoustic neuroma or other brain tumor.

In Ménière's disease, the ear, nose, and throat examination is usually negative except for the hearing tests and equilibratory tests. The hearing tests will show, in the majority of cases, a nerve type of hearing loss on the side involved. This may occasionally be bilateral. The equilibratory tests that we have carried out were done so after the manner of Kobrak, using cold water. There is usually some abnormality of the labyrinth found on caloric tests. It may be evidenced by hypoactivity or hyperactivity. It is important in patients with a history of vertigo to check the corneal sensation and reflex. This is found to be normal in patients with true Ménière's disease. Patients with an angle lesion may have as a first sign decreased or absent corneal sensation. Nystagmus, spontaneous in origin, is present only during the episode of vertigo.

TREATMENT

Many methods of treatment, both medical and surgical have been described in the literature. The surgical procedures that are being accepted today are those in which surgery to the labyrinth or on the eighth nerve is carried out. Only the more accepted surgical procedures will be mentioned here. In 1938, Wright and Peacock suggested total ablation of the labyrinth by means of injection of alcohol through the oval window. Mollison has advised opening the horizontal canal and later also suggested the injection of absolute alcohol into the canal. In 1911, Jenkins reported a case in which a fenestration operation was performed, the opening being made into the perilymphatic space of the horizontal canal. After the operation, the hearing improved and the vertigo disappeared. Page, in 1913, reported a case in which a labyrinthectomy of the Hinsberg type resulted in a cure. In 1943, Day reported on the application of a coagulating current to the vestibule in cases of intractable vertigo of the labyrinth. This was carried out through a postauricular approach to the mastoid antrum. The horizontal canal was exposed, and just medial to the short process of the incus, a small opening was made into the canal with a motor driven burr. A light coagulating current was then passed through a small needle

introduced through this opening towards the medial wall of the vestibule. Goodyear has reported success in a similar procedure in which he uses a small dental excavator to destroy the utricle. Portmann has referred to this disease as auricular glaucoma and he believed that increase in endolymphatic pressure on the endings of the vestibular and cochlear nerves produced a functional disturbance which was the factor in the production of symptoms found in Ménière's disease. He advised surgical decompression by opening the sacculus endolymphaticus. Cawthorne in a recent article presented an interesting review and has discussed the results of various operative treatments on the labyrinth.

Dandy has presented many articles in regards to the treatment of this disease by intracranial division of the auditory nerve. In 1928, he reported nine cases in which the auditory nerve was sectioned. None of the patients reported had subsequent attacks of vertigo. It was his opinion that this condition is primarily a lesion of the nerve and that the symptoms are similar to the paroxysmal attacks one finds in trigeminal or glossopharyngeal neuralgia. Later he discussed the advantages of partial section of the auditory nerve in an attempt to sever only the vestibular fibers. It is interesting to note that from his observation, a half to four fifths of the cochlear portion of the nerve may be divided with practically no loss in hearing. In 1941, he presented 401 cases. In 50 per cent of these, the tinnitus disappeared after division of the nerve.

THE DRUGS

Under medical treatment various drugs have been suggested. Only the accepted medical therapy as used today will be presented. In 1938, Mygind and Dederding expressed the opinion that disturbed water metabolism is the cause of this syndrome. They suggested the use of atropine in the acute attacks. With the use of restricted fluid intake, they reported 81 per cent of the patients treated were permanently free of giddiness after three years or more. In 85 cases out of 150, the hearing improved. In 47 cases, the hearing returned almost to normal and in 24 cases the hearing had not improved or had decreased. Furstenberg, Lashmet, and Lathrop believe that the accumulation of water is not due to water alone, but to electrolytes, chiefly sodium salts. They suggested that sodium intake be reduced to a minimum and that sodium also be prevented from accumulating in the body. For this they advised hospitalization of the patients and the use of a carefully supervised diet free of sodium chloride. Successful results were reported in fourteen cases. Ammonium chloride was administered, nine grams daily for a period of three days with discontinu-

ance of the drug for the following two days. In 1940, Walsh and Adson considered the relative merits of medical and surgical treatment. They treated 128 patients according to Furstenberg's regime with moderate success. Using a modification by substituting potassium nitrate for the ammonium chloride, more improvement was found in their series of 94 cases. In 1940, Talbott and Brown studied the acid-base equilibrium of the blood and found no abnormal changes in patients suffering from Ménière's disease. They found that the administration of sodium salts and soda bicarbonate could be carried out without precipitating an attack. They administered six to ten grams of potassium chloride a day and employed a low salt intake on 48 patients. Improvement in vertigo was noted in all of these cases. In some cases, hearing and tinnitus also improved. In 1938, Alfody reported the use of non-specific histamine therapy with good results. In 1940, Sheldon and Horton first reported the intravenous use of histamine in the treatment of Ménière's disease. In 1941, Horton⁵ reported 49 cases in which this method of treatment was used; 2.75 mg. of histamine diphosphate (1 mg. of histamine base) was administered intravenously in physiological salt solution (250 cc.). Various vehicles were later used to check the effect upon the symptoms, namely a 5 per cent solution of dextrose or an 0.8 per cent solution of potassium chloride. This was given at the rate of 20 to 60 drops per minute. The blood pressure and pulse rate were checked frequently during injection. Histamine was administered daily in this manner for three to six days. In conjunction with or following the above intravenous injections, subcutaneous administration of histamine was begun. This was administered in a 1-10,000 solution of histamine base consisting of 0.275 mg. histamine acid phosphate per cc. The initial dose was 0.20 cc. and this was increased by 0.05 cc. twice daily up to 1 cc. or until the optimal dose was reached. The patient was then instructed to continue with the daily injections of histamine and gradually taper off the dose according to the response to treatment. In several cases where the symptoms were especially severe, the intravenous injections were administered for many days. In some cases, histamine was administered intravenously during the subcutaneous desensitization to abort an attack of vertigo. In 1944, Lillie, Horton, and Thornell⁶ reported their observations on the hearing in patients with Ménière's disease in which Horton's regime was used.

In 1940, Harris and Moore made an excellent review of Ménière's disease. As perceptive deafness associated with vertigo is suggestive of a degenerative process and as many pellagrins have a rotatory vertigo, these investigators used

nicotinic acid and thiamine in the treatment of this syndrome. In 17 of 20 cases, the patients became entirely free of vertigo and the remaining three were improved. Ten patients noted marked relief of the tinnitus. Twelve patients reported marked improvement in the hearing, while the hearing remained stationary in the remaining cases. The treatment they advised consisted of the administration of 250 mg. of nicotinic acid each day in five divided doses and 10 mg. of thiamine twice a day. Atkinson divides cases of idiopathic Ménière's disease into two groups on the basis of the reaction of the patients to histamine. In the larger group the patients are insensitive to histamine and the syndrome is the result of a primary vasoconstriction with a secondary vasodilatation. The intradermal tests are carried out with histamine by using 0.0057 mg. of histamine base which is equivalent to 0.10 mg. of histamine dihydrochloride. According to Atkinson, a positive reaction is based on the appearance of pseudopodia. In cases in which the patients are sensitive to histamine, patients are desensitized slowly. The intradermal skin test is repeated subcutaneously every two to four days. Thereafter, the drug is administered subcutaneously in gradually increasing doses. On attaining the maximal dose, it is repeated at intervals of four weeks. A second course has been suggested after six months and possibly a third course. In patients showing an insensitivity to histamine, nicotinic acid is used because of its vasodilating effect. An initial dose of 25 mg. is administered intramuscularly. This is gradually increased to the limit of tolerance and is maintained at that level for approximately a month. Then it is gradually decreased. The doses vary considerably, the extremes of variation being 10 mg. intramuscularly, 400 mg. intravenously, and 300 mg. orally. In some of his earlier patients, vitamin B-1 was also given in conjunction with the nicotinic acid. Williams believes that in cases of vertigo there is a gradation from postural types up through tinnitus and vertigo without deafness, to the classic Ménière's disease. He has observed good results in cases in which histamine or nicotinic acid was administered regardless of the reaction of the patients to intradermal tests with histamine. I have also made similar observations.

NICOTINIC ACID

The use of nicotinic acid has been advocated by H. L. Williams.⁴ He advised that patients be started with 25 mg. of nicotinic acid and increased by 25 mg. twice a day, until 100 mg. is obtained. This is given subcutaneously. Daily injections of 100 mg. are then given for a thirty-day trial and in a small number of cases, it is necessary to supplement this with a salt-free

diet, limited fluid intake or potassium nitrate. The potassium nitrate is given orally, one gm. four times a day. If improvement is definite, the patient is advised to continue with the subcutaneous injections of nicotinic acid and he is instructed as to how to give the injections to himself. The injections are continued for a period of three months. He is then placed on the nicotinic acid by mouth; 100 mg. of nicotinic acid is given twice a day, one half hour before eating. It is necessary to increase the amount of nicotinic acid when taken by mouth because of the difference in absorption as compared to the subcutaneous route. There are many patients who will be seen, who will show as much improvement when taking the nicotinic acid by mouth as by injections, but on reviewing a large number of cases, it has been found that the greatest percentage of improvement will come from the subcutaneous injections of nicotinic acid. More recently with the introduction of Benadryl and Pyribenzamine, we have two more drugs to add to our armamentarium in the treatment of this condition. The number of patients so treated is quite small and compared to nicotinic acid, the results are not as good. A comparison of nicotinic acid and histamine show equal results in response.

In my experience, as well as the experience of others, we have found many patients who may show marked improvement on any of the above-listed medical regimes and after a period of time, will show some return of their symptoms. The addition of supplementary substances or changing from one to the other will again provide immediate improvement. The treatment of the acute attack is handled very well with the intravenous administration of histamine. Adequate medical treatment should always be instituted before surgery is considered.

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In regions where histoplasmin sensitivity is widespread, pulmonary infiltrations as well as calcifications are frequently nontuberculous, and can be differentiated from tuberculosis only by skin tests at present.—Michael L. Furcolow, M.D., Herbert L. Mantz, M.D., and Ira Lewis, M.D., *Pub. Health Rep.*, Dec. 5, 1947.

Severe Allergic Sensitization to an Estrogenic Cream

Mrs. E. P.* was admitted to the University Hospitals on July 17, 1947, with the complaint of persistent giant urticaria of nine weeks' duration. It had failed to respond to elimination diets and to the elimination of all oral medications. Ephedrine, Adrenalin, pyribenzamine, and Benadryl gave only temporary partial relief. She knew of no sensitivities to drugs, foods, inhalants, or contactants. She also denied having hay fever, rhinitis, or asthma. There was no known family history of allergy.

The remaining past history and system review was non-contributory except that the patient had received estrogenic injections for several months, five years previously, for relief of menopausal symptoms. Careful questioning elicited no other history of contactants.

Physical examination revealed a normally developed and well-nourished white female of 52 years of age with numerous disseminated urticarial lesions on the trunk, extremities, and face. Other findings were non-contributory.

Intradermal skin tests to various foods, contactants, and inhalants showed a few three plus or two plus reactions.

On the eighth hospital day there was a severe urticarial reaction over the face and neck with generalized giant lesions. The eyes were swollen almost shut. Careful detective work revealed that her husband, on her request, had brought up from Akron a boric acid and antipyrine eyewash, a proprietary cold cream, a nail lacquer, and an estrolar cream. On the container it was stated, "Containing natural estrogens, essentially estrone and estradiol and triolein ozonide." Frequent use of the eyewash and patch tests to the cold cream and nail lacquer did not cause a local reaction or exacerbation of the symptoms. However, after the estrolar cream had been in contact with the skin for one hour, there was a severe pruritus and within two hours the patient had more urticarial lesions over the face, trunk, and extremities than she had at any previous time since her admission to the hospital. The site of the patch test was a giant urticarial lesion. It was necessary to administer Adrenalin subcutaneously to relieve the acute distress.

Following this experience the patient, who previously had denied the use of all such compounds, was able to associate exacerbations of her urticaria with applications of the cream to the face and hands. She had been using this preparation twice weekly for over a year.—HAROLD N. COLE, JR., M.D., WILLARD L. MARMELZAT, M.D., AND ALLEN E. WALKER, M.D., Cleveland, Ohio.

*Kindly referred to us by Dr. Paul R. Adams, Akron, Ohio.

The Acute Gallbladder

ROBERT M. ZOLLINGER, M. D., and HAROLD T. GROSS, M. D.

THE problems associated with the treatment of biliary tract disease are among those most commonly encountered by the clinician. Complaints involving the biliary system will be even more common in the future, since vital statistics show a definite increase in the span of life, and since it is in the elderly that the incidence of gallstones reaches its peak. Although the surgical mortality is quite low for operations performed on the biliary tract at a time of election, the mortality is much higher where complications such as acute cholecystitis or common duct stone occur. Perhaps the physician should be more emphatic in recommending surgery following the initial discovery of gallbladder disease, regardless of the age of the patient. He should weigh the risks of surgery in the early stages as a preventive measure against a probable higher mortality rate among such patients in later years, from such a complication as acute cholecystitis. In a population of increasing longevity, this principle is assuming a place of greater importance. Every physician should review all aspects of his own management of gallbladder disease from time to time to determine whether his methods assure the lowest possible morbidity and mortality.

PATHOLOGY

The conflicting opinions regarding the optimum time for operation in cases of acute cholecystitis have largely been based upon studies of the pathologic process involving the gallbladder. For many years it was assumed that bacterial invasion was invariably associated with acute cholecystitis, and clinical treatment was based on this theory. However, studies in recent years tend to show that the significance of a highly infectious bacterial process in acute cholecystitis has been definitely overemphasized, inasmuch as bacteriologic and histologic investigation frequently fails to demonstrate the presence of organisms. Likewise, the character of the inflammation differs considerably from the conditions ordinarily caused by bacterial irritants. Smears and cultures from the wall of the acute gallbladder, as well as from its contents, are often negative. While infection may play a leading role from the start in some cases of acute cholecystitis, in the majority of cases it is probable that infection is a process superimposed on already damaged tissue.

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Investigations in recent years tend to show that acute cholecystitis is the result of a chemical rather than bacterial irritation. It has been proven that following the sudden obstruction of the cystic duct, which may be caused by a calculus or even a slight degree of inflammation, a series of changes take place, resulting in a marked concentration of the contents of the gallbladder. The bile salts are absorbed, and an increase in the calcium carbonate, sodium chloride, and cholesterol content results. This concentrated mixture produces an irritation of the gallbladder mucosa resulting in the typical marked distention and enlargement of the gallbladder with a greatly thickened and edematous wall. The gallbladder therefore appears to behave as a dialyzing membrane filled with a hypertonic solution. This pathologic edema of the wall actually facilitates the enucleation of the gallbladder since it develops a relatively avascular cleavage plane between the serosa and the fibromuscular layer. The contents of such a gallbladder may be thick and white, resembling pus. Frequently, however, bacteria cannot be demonstrated by smears or cultures. The so-called "pus" is, in reality, a concentrated chemical solution.

One of the more serious and frequent complications of acute cholecystitis is perforation (approximately 12 per cent). It has been postulated that the perforations may occur through the Rokitansky-Aschoff sinuses which extend into the wall of the gallbladder. These sinuses may extend through all layers to the serosa, producing a weak area through which perforation occurs as a result of overdistention of the gallbladder. Although the entire gallbladder may become gangrenous, it most commonly involves the area of the fundus. While the omentum or liver usu-

ally seals off these perforations, free perforation into the general peritoneal cavity is not uncommon.

SYMPTOMS

The typical case of acute cholecystitis is easily diagnosed clinically by pain in the right upper quadrant associated with varying degrees of nausea and vomiting, muscular rigidity, fever, and leucocytosis. Often there is a fairly long history of recurrent attacks of biliary colic, but in some there is no record of previous symptoms referable to the gallbladder. It is to be emphasized, however, that in early cases there may be only epigastric pain and sometimes substernal distress associated with shortness of breath, which may so simulate a cardiac disturbance that a diagnosis of gallbladder disease may be overlooked. The epigastric pain, nausea, and vomiting results from the distention of the cystic duct caused by the offending calculus. Early in the attack a mass may not be palpable, and there may be little clinical or laboratory evidence of inflammation, the entire symptomatology being explained on the distention of the cystic duct. Localized tenderness and rigidity of the right upper quadrant may not appear until the gallbladder becomes distended, and the overlying peritoneum is irritated. In some instances the clinical syndrome is complicated by an associated acute pancreatitis. An X-ray film of the abdomen may show the presence of calculi in the gallbladder area or a hazy shadow in the right upper quadrant, indicative of a pathologic process in that area.

CONTROVERSY OVER TREATMENT

Until recent years there was general agreement that the policy of "watchful waiting" in the treatment of acute cholecystitis gave the best results. This was based on the observation that the acute signs and symptoms usually subside, and hospitalization was even deemed unnecessary. Many patients who had been treated in the hospital during their acute episode were discharged with instructions to return in several months for cholecystectomy. It was thought that the patient would be in better condition for operation. Technically, the surgical procedure would be far easier and safer, and fewer two-stage operations would be required. Early operation was usually not practiced unless there were obvious signs of a progressing inflammatory process involving the right upper quadrant, or evidence of a free perforation.

Those favoring early operation^{2,3} point out that while the majority of patients recover promptly, the clinician is unable to predict the response of the patient to conservative treatment. Furthermore, they say that the severity of the inflammatory process is often much greater than the physical signs and laboratory data indicate. For

these reasons, the patient with acute cholecystitis should always be hospitalized just as in appendicitis. After fluid balance is established, they believe there is little reason to delay operation because of the danger of spreading infection. The inflammatory process is apt to be chemical in the early stages, and not bacterial. The problem of infection would be encountered more frequently if surgical therapy were delayed for a longer period of time. It is also pointed out that the acute gallbladder develops its own line of cleavage in the edematous seromuscular coat which facilitates enucleation. Those advocating early operation tend to show a lower incidence of complications and obviously a shorter period of hospitalization. The strongest argument in favor of early operation has been the fact that a substantially lower mortality is reported than when the traditional conservative policy is rigidly adhered to. It should be pointed out that the most earnest advocates of early surgery probably do not operate upon the patient with acute cholecystitis as early as in the case of the patient with acute appendicitis. Actually, there appears to be a combination of two schools of thought, and each patient is treated as an individual surgical problem.

PLAN OF TREATMENT

Once the diagnosis of acute cholecystitis has been made, it is urged that the patient be hospitalized immediately, regardless of how minor the signs and symptoms may be. Morphine and atropine are used for the relief of pain, with the frequency of administration used as an index of the patient's progress. Nitroglycerin is also effective in controlling severe pain. An estimation is made of the extent and severity of the inflammatory processes involving the gallbladder. In addition to the routine laboratory work, determinations of the blood sugar, urea nitrogen, prothrombin, CO₂ combining power, chlorides, plasma proteins, and blood amylase are made to establish a base line for chemical balance. These additional tests obviously are more essential in the severe cases. However, a routine blood amylase is taken to rule out an associated pancreatitis. We have observed a definite increase in the incidence of this disease as a result of obtaining a blood amylase in every one of these acute cases. The restoration of the fluid and electrolyte balance is begun by the introduction of intravenous glucose in saline or distilled water, the amounts being determined by the clinical condition of the patient as well as the laboratory findings. Supplementary vitamins including vitamin K are given. Constant gastric suction is instituted if there has been vomiting or evidence of distention. All of these measures are more or less routine in any patient showing evidence of intra-abdominal inflammation. The use of penicillin and sulfa drugs, however, are prob-

ably of little value in cases of acute cholecystitis. It has recently been shown that occlusion of the cystic duct, which is the most important single factor in this disease, will prevent the concentration of these drugs within the gallbladder.⁴ Furthermore, the pathologic process is on a chemical and not a bacterial basis. Accordingly, we have not used chemotherapy in our recent cases of acute cholecystitis.

The temperature, pulse, and respiration are recorded every two hours and a white and differential count is made every three to eight hours. Frequent examinations and observations of the clinical signs and symptoms of the patient are also made. It has been found useful for subsequent comparisons to have the limits of the right upper quadrant mass outlined on the skin of the patient. The vital capacity is determined upon admission and several times daily as additional evidence of an expanding or decreasing process. The irritating effect of the disease upon the diaphragm will definitely lower the vital capacity due to the pain produced by motion of the diaphragm. A great lowering of the vital capacity will occur as the gallbladder distention and the disease progresses. An increase in temperature, pulse, and respiratory rate, an increased white and differential count, a decreasing vital capacity, and persistent or increasing signs of pain and tenderness in the right upper quadrant are all indications of a progressive pathologic process. The presence of a well-defined mass in the right upper quadrant, increasing in size, is also indicative of progressive pathology with impending perforation. A probable gangrenous process with possible perforation should be considered if the white cell count is elevated to 20,000 or above.

The optimum time for operation depends entirely upon the general condition of the patient and the progression of the pathologic process as determined by the frequent evaluation of the clinical signs and symptoms as well as the laboratory findings. There are no set rules or predetermined classifications which fix the time when operation is to be performed. Certainly, routine management is unsatisfactory, and each case should be evaluated and managed as an individual problem. In our experience, the majority of patients with acute cholecystitis have had their attack longer than 24 hours before entering the hospital, so that it would be impossible to carry out surgery in the majority of cases within 48 hours of the onset of the acute attack, as recommended by some. Furthermore, we have observed that about three patients out of four with acute cholecystitis will respond to the usual conservative measures, and operation is performed within a week after admission. However, it should be remembered that 20 per cent of the patients, or one in five, fail to improve

with conservative and supportive measures so that operation is performed, after fluid balance is established, within 36 to 48 hours after admission. About five per cent of the patients, or one in twenty show rapidly increasing signs and symptoms raising the question of free perforation, making surgery mandatory as soon as they can be prepared for operation. A free perforation may occur within a matter of hours after the onset of the acute attack.

OPTIMUM TIME FOR OPERATION

We have reached four general conclusions in determining the optimum time for operation:

1. While we have not had an opportunity to operate upon many patients within 24 to 48 hours after the onset of acute cholecystitis, we are in accord with those who favor early operation in "good risk" patients.

2. Early operation is imperative if there are signs of generalized peritonitis, implying a free perforation of the gallbladder.

3. Operation should be considered if the signs and symptoms do not improve within 24 to 36 hours after admission into the hospital. A leucocytosis of 20,000 or above is indicative of impending gangrene.

4. Finally, surgery should be carried out if the patient doing well on conservative management has a recurrence of pain requiring additional morphine; develops a higher temperature and leucocytosis, a flare-up of the signs of inflammation, or an increase in the size of the mass in the right upper quadrant.

The mortality rate will be lowered when more patients with acute cholecystitis are operated upon at any time during the day or night, if after fluid balance is established, they do not show evidence of continuous improvement under conservative management.

It is believed desirable to delay operation in those patients seen late in the course of their disease and already having decreasing signs and symptoms. We believe, however, that after several days these patients can be subjected safely to surgery and should not be sent home to run the risk of a recurrent episode. Operation is likewise delayed or may not be recommended in elderly or "poor risk" patients who promptly respond to conservative measures. However, with the increase in the life span, the physician and surgeon must accept the responsibility of treating those in the older age group. Although the mortality rate is usually higher for any type of surgical procedure in patients above middle age, there is no contraindication to advising surgical interference in acute cholecystitis in the older age group. By careful pre- and postoperative care, a low mortality can be attained. It is apparent that the optimum time for recommending surgery is during the early stages of disease, when the

patient is a better risk and free of complications. This fact should be given careful consideration by physicians.

SURGICAL TECHNIC

The type and extent of the surgical procedure usually cannot be determined until the peritoneal cavity is opened and the local pathologic process involving the gallbladder is evaluated. The general condition of the patient, the presence of an abscess, and the technical difficulties encountered in isolating the gallbladder, especially in the region of the ampulla and cystic duct, determines the type and extent of the operation. Although cholecystectomy is the operation of choice, it may be better judgment to decompress the gallbladder, remove the calculi, and institute drainage by means of cholecystostomy. In general, this principle is followed in "poor risk" patients in whom minimal surgery is desirable, or when an abscess is encountered, or when technical difficulties make cholecystectomy hazardous. In the latter group, the surgeon should consider partial cholecystectomy, which has proven a valuable procedure in many cases, and which deserves more widespread use as a substitute for cholecystectomy. No effort is made in partial cholecystectomy to isolate the cystic vessels or duct. After splitting the gallbladder from the fundus down to the region of the ampulla, the excess gallbladder is trimmed away, leaving that portion adjacent to the liver undisturbed. Bleeding points along the edematous, thick cuff of the gallbladder wall are individually ligated. An attempt is made to anchor a small catheter into the cystic duct and Penrose drains are inserted. It is unnecessary to attempt to destroy the remaining gallbladder mucosa by either chemical or actual cauterization.

In the majority of cases, cholecystectomy can be performed without troublesome bleeding, if advantage is taken of the edematous subserosal layer of the acute gallbladder. However, the surgeon should keep in mind the possible dangers in performing a cholecystectomy. In the first place, the gallbladder may be avulsed from the liver bed if too much traction is applied to it before an incision is made through the serosa in order to develop a subsequent cuff of tissue for closure. Otherwise, bleeding, raw liver is exposed and a satisfactory closure of the gallbladder bed is impossible. Secondly, there is a danger of injury to the common duct if clamps are applied to the region of the distended ampulla of the gallbladder before it has been isolated from the adjacent structures by finger or blunt gauze dissection. Thirdly, it should be remembered that the common duct, the cystic duct, and vessels, including the right hepatic artery may be drawn up into an unusual position as a result of the inflammatory process.

Accordingly, in many instances, it is desirable to evacuate the contents of the gallbladder and remove it from the fundus downward in order to more easily and safely identify and ligate the cystic duct and artery.

CONCLUSIONS

1. Immediate hospitalization of the patient is imperative when a diagnosis of acute cholecystitis is made, because it is impossible to predict the subsequent course of this disease, and subsiding clinical signs and symptoms do not always indicate the extent of the pathologic process.

2. The fundamental treatment of acute cholecystitis is surgical, preferably cholecystectomy, following adequate preoperative preparation. The time of operation is determined by the frequent evaluation of the clinical and laboratory findings.

3. In general, early operation is imperative in the face of mounting clinical and laboratory findings, but may be delayed in the presence of subsiding signs, with cholecystectomy performed during the same hospital admission.

4. Cholecystostomy and partial cholecystectomy are procedures of choice in the "poor risk" patient, in the presence of an abscess, or when technical difficulties make cholecystectomy hazardous.

5. The mortality rate in acute cholecystitis can be substantially lowered:

- a. If operation is performed early, within 24 to 48 hours of admission to the hospital, when there is no improvement to conservative management following adjustment of the fluid balance.
- b. If early operation is performed when there are signs of generalized peritonitis present.
- c. If surgery is performed immediately upon recurrence of the signs and symptoms while on conservative treatment.

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If streptomycin were perfectly harmless, it could be given to every patient with active tuberculosis regardless of the nature and extent of the tuberculous disease and its complications. However, streptomycin is not perfectly harmless. This must not discourage us, since many of our most useful drugs are injurious if given unwisely.—James J. Waring, M.D., J.A.M.A., Jan. 31, 1948.

The Treatment of Varicose Veins During Pregnancy by Combined High Saphenous and Segmental Ligations Followed by the Injection of the Residual Varicosities

PAUL J. SHANK, M.D.

THIS study is based on a group of 30 patients, which is a small but representative series. It is presented with the hope that others will carry out the operation to further ascertain its true value.

Opinions given here are unbiased, inasmuch as five obstetricians have contributed by referring the patients. Hence, the author has not been the sole judge in their selection. The obstetricians referred these patients whose varicosities were so severe that they themselves felt therapy was indicated.

The patients must be carefully selected, as this is not a procedure recommended for all pregnant women with varicosities. It is for that group who have severe grade III and IV varices which produce symptoms.

The incidence of post partum thrombophlebitis is less than one per cent in all pregnancies. Most of these occur in the group of grade III and IV varices. It is the belief that treating the varices of this group will further reduce the incidence of this complication.

REVIEW OF LITERATURE

In a recent review of the literature the author was unable to find any article presenting the treatment of varicose veins during pregnancy by combined high saphenous and segmental ligation followed by the injection of the small residual varicosities. McPheetus¹ in a recent article flatly states that ligation of varicose veins during pregnancy has been 100 per cent failure. On the other hand, the author has obtained uniformly good results and believes it is due to the radical operation followed by frequent injection of the residual varices. In a personal communication Ochsner² states that this is the exact mode of treatment carried out in their clinic.

It is generally recognized that the state of being pregnant is influential in the production of edema and varicose veins in the lower extremities. The mechanism responsible for these symptoms has never been clearly demonstrated. The symptoms are entirely absent in many patients, are mild in others, and severe in still others. There is some anatomical or physiological factor or peculiar predisposition in some pregnant women. This is suggested by the variability of the time of onset, by the extent and course of the edema, and by the varicose veins. Such

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manifestations are common complications of pregnancy in all races and in all classes. Therefore it is not logical to assume the existence of any predisposition such as congenital weakness of the valves of the venous system.

Certain physiological changes occur during pregnancy that may alter the venous circulation in the lower extremities. It is generally accepted that there is an increase in the total blood volume. There is also an increase locally in the volume of blood in the pelvic veins. This is due in part to the augmented vascular supply incident to the growth of the uterus and also to the formation of the arteriovenous communications in the placenta. These physiological changes are found in every pregnancy and consequently do not explain the variability of occurrence of varicose veins and edema. Furthermore such changes are scarcely of sufficient magnitude to account for these symptoms.

Changes in the anatomy of the pelvic organs during pregnancy produce considerable obstruction to the venous return from the lower extremities. Furthermore the anatomical changes are variable. The position and size of the uterus, the length and mobility of the supporting ligaments, the size of the pelvis, and the tone and development of the abdominal muscles, all may vary to some degree in pregnant women. Such anatomical variations may account for difference in the degree of obstruction to the outflow of blood from the lower extremities. In some women the obstruction may be sufficient to produce varicose veins and edema.

If obstruction of the femoral-iliac veins is the principal factor in the pathogenesis of edema and varicose veins in pregnancy, it is logical that the most direct approach to the early detection of these disturbances might be by measurements of the blood pressure in the veins of the lower extremities.

Veal³ has shown by popliteal venous pressure

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curves taken in the erect position that postural dependent edema and varicose veins of the lower extremities in pregnant women are due to localized obstruction of the deep veins. However he was unable to determine the factors responsible for increasing the degree of localized venous obstruction in some pregnancies to the point of causing edema or varicose veins. The size and position of the uterus are factors of recognized importance.

ANATOMY

The venous system of the lower leg is composed of a deep and superficial set of veins united by a rich network of anastomosis. In addition there are communicating veins connecting the two sets which are variable in number and location. These are equipped with valves which permit the flow of blood from the superficial into the deep veins, but do not normally permit it to flow from the deep to the superficial veins. The valves in the saphenous group prevent a reflux of blood and maintain the column of blood above them. The deep veins composed of the femoral, popliteal, anterior, and posterior tibial and their tributaries are located beneath the deep fascia. These veins are surrounded by the powerful muscles of the leg, which prevent them from dilating when subjected to pressure. The pumping action of the muscles in walking aids in emptying the veins.

The superficial veins lie in the subcutaneous fat of the leg forming a network of the long and short saphenous and their tributaries. These veins lack the muscular support and pumping action of the muscles of the deep set veins and therefore may dilate under excessive pressure and form varicosities. The long saphenous originates from the foot and ankle medially, anteriorly and courses upward until it enters the deep system at the foramen ovalis. The short saphenous originates from the foot and ankle laterally and posteriorly and passes upward until it joins the deep system in the popliteal space.

McPheeters⁴ has found in his dissections that often along the entire course of the long saphenous there are small normal veins lying close to and often parallel with the varicose veins. He points out that this anatomical relationship may cause the recurrence of veins a few years after injection treatments have been given. Kampmeier⁵ found constantly a valve one and a half to two centimeters above the saphenofemoral junction. Usually six to twelve valves were found in the long saphenous vein. The valves were usually located at the entrance of the saphenous, into the femoral and into the popliteal. They were often below the opening of a tributary, but this was not constant and there seemed to be no regularity whatsoever in their location. They found the majority of valves in the saphenous

system were of the bicuspid type as were also those of the other veins in the leg.

ETIOLOGY

There is no general agreement as to the etiological factors in the production of varicose veins. Most investigators agree that there is a deficiency in the valves. The *mechanical explanation* was first given by Delbet⁶ when he explained that the loss of valve function was the first step in all cases. The back pressure from the iliac vein he believed caused the valves at the saphenofemoral junction to give away, allowing a reverse flow to develop in the leg. Any increase of intra-abdominal pressure as in coughing, sneezing, or lifting will produce back pressure. In a like manner any obstruction to the venous return as in pregnancy, pelvic tumor, thrombosis of sacro-iliac veins, or cirrhosis of the liver will increase this pressure. Valves do not lose their competency in succession. There is a progressive degeneration of the valves with age. It is known that many more valves exist during fetal life than are accounted for at birth and many do not survive the adult period. The *endocrine factor* must be considered as playing a part. This is manifested by general connective tissue weakness, loss of nerve and muscle tone in the walls of the veins, and by congenital weakness of the valve. There is a question as to whether the primary factor is an inherent weakness and deficiency of the valves or an inherent weakness of vein wall itself. Many people doubtless have an inherent degree of valvular weakness but never develop varicosities because no exciting factor enters their lives for a sufficient period to exert its dilatating effect. There is also an infection theory. *Occupation* may be a contributing cause. The main factors responsible for the venous return of the blood from the lower extremities are: first, abdominal thoracic suction; two, skeletal muscular contraction and relaxation; three, vis a Tergo, which Dalcan describes as a force with which blood enters the venous radicals from the capillaries. It is a continuous acting force and during muscular relaxation forces the blood into the small veins past the first valves, at which time it comes under the influence of muscular contraction. Therefore, those whose occupation demand long hours of standing, such as barbers, clerks, etc., their pumping action is lost and continuous back pressure of the venous column results. The saphenous being the longest vein of the body is the one most commonly affected. The *vitamin theory* is the most recent, and is based upon the absence of vitamin C.

CLASSIFICATION

Type 1: Consists of fine cutaneous dilatations of the stellate design. These are similar to

what McPheeters⁷ calls skyrocket or spider burst, and are usually seen on the external surface of the thigh in fleshy women.

Type II: This is the isolated sacular varix usually appearing along the course of the great saphenous vein.

Type III: This is the fully developed tortuous cavernous mass of varices either in the great or small saphenous vein.

Type IV: This is the varix of uniform dilatation of a large trunk. The walls of these veins are markedly hypertrophied and undergo a dilatation with persistent increase in pressure. This may be seen on all parts of the thigh and lower leg.

PATHOLOGY

Although the cause of varicosities is not definitely known we do understand the tissue changes which take place. The collagenous tissue of the endothelium proliferates and invades the muscular and elastic tissue. The round cells can be found around the nutrient vessels and secondary calcification may take place. The veins lose their elasticity and may become very thin while the valves become incompetent and the pressure in the vein increases. The increased pressure together with alterations in the veins permits the blood to escape into the tissues which may produce edema, loss of tone, pigmentation, poor nutrition, inflammation, dry scaly or eczematous skin, and ulceration. The stagnation of blood from increased pressure in the varicose veins must result in changes in the blood chemistry. de Takats, et al.,⁸ have shown in carefully controlled experiments that the carbon dioxide content of the varicose blood is definitely higher than that of the venous blood in the cubital veins of the same person. The reverse is true of the oxygen content. It has always been the assumption that in varicose veins the upward flow of blood is markedly slow, and the varices remain as dilated tubes of blood. McPheeters states that the Trendelenburg test⁹ is merely a test proving the reverse flow of blood in the great saphenous veins from the sapheno-femoral junction downward. This test is positive in all cases with extensive varicose vein development. He further states that the same phenomena of a downward or reverse flow develops from a blowout or wide dilatation of any of the communicating veins from the deep system and any place along its course upward. He also adds that it occurs more often in the lower leg as the communicating branches are more apt to dilate in this location. McPheeters has proven by blood pressure experiment that the blood is slowed or stagnant in any case of varicose veins. When the patient is walking, the flow actually may be reversed, being outward from the femoral by the way of the communicating and downward by the way of the

varicose saphenous system. Once the varicose veins dilate and the valves become incompetent as during pregnancy, they rarely return to their normal competency. It may be analogous to the valvular murmurs which arise in heart lesions.

DIAGNOSIS

Diagnosis of varicose veins is usually not difficult, but hidden varicosities due to excess or brawney edema may occasionally cause confusion. Physical finding in varicosities consists in varying degrees of dilatation and tortuosity of the veins. The large dilatations as a rule are located on the posterior or medial aspect of the knee. In very obese individuals the varicosities cannot be easily visualized. Transmission of an impulse by percussion along the course of the veins is indicative of varicosities and also indicates incompetency of the venous valves. The Trendelenburg test is the one most commonly used to determine the reverse flow. The varicose condition is studied with the patient in a standing position and at this time the compression pulse is observed along the course of the vein to the groin. In starting the Trendelenburg test, the patient lies down and the leg is elevated to empty the varicosities. Pressure is then made over the sapheno-femoral junction to block any outward flow. The patient then stands, and if there is marked reverse flow from the groin when the pressure is suddenly released, the empty varicosities will fill rapidly and the test is positive. If the varicosities fill slowly with the normal accumulation of blood from the distal areas but fill more rapidly when the pressure at the groin is released, then the test is still positive. We may also have the condition in which the reverse flow is outward through a perforating vein in the upper or lower leg.

In the negative test the veins will fill rapidly and not become more tense when the pressure above is removed. There are some rare cases in which there is both outward and downward flow from both sources. This is called a Trendelenburg positive double test. Perthes test is the one most commonly used to locate reverse flow through a perforating vein in the lower thigh. It is made by applying a rubber tourniquet about the leg and having the patient walk rapidly from fifty to a hundred steps. The normal pumping effect of the calf muscles with each step will suck the blood inward from the varicosities and thus the varicose segments above the tourniquets will remain filled while those below will be empty. If the test is positive the empty veins will quickly fill from above as the tourniquet is removed. Multiple tourniquet tests of Oschner and Mahorner¹⁰ are merely the reapplication of the Perthes test at different levels until the offending vein or veins are located. The Pratt

test uses two bandages about the leg to locate the perforating vein.

One bandage is applied very tightly from the toes to the groin, the second bandage is then applied from the groin downward leaving about four inches between the bandages. With this procedure perforating veins can then be seen as they appear. The final proof as to whether the enlarged veins are varicosed or competent can be determined by the bandage test. In this test a firm four-inch bandage is applied to the lower legs from the knees down to the toes going twice about the ankle and twirled in a figure of eight. The patient is then told to walk quite rapidly for five blocks. If he develops a pain in the lower leg, and particularly if the pain increases then the bandage should be removed. However if the pain has not increased after he has walked the five blocks, he is advised to continue walking for another five blocks with regular intervals of rest. He should then report back to the office for examination. If the pain lessens the bandage should not be removed until bedtime. If the varicosities are competent the patient will have severe pains in the leg and foot while walking. If, however they are typical varicose veins with a stagnant and reverse flow the patient will feel better the faster he walks. Following a rapid ten-block walk, the toes will be pink, the edematous leg will be much softer and the patient's leg will feel better. We must always be alert for complicating diseases, such as diabetes, cardiorenal condition, or the presence of a toxic thyroid. High blood pressure is not a contraindication.

TREATMENT

The treatment of varicose veins resolves itself into three classes: One, palliative; two, injection of sclerosing agents; three, ligation of the saphenous veins plus injection. One: The palliative treatment, consists in the wearing of elastic stocking or bandages. The elastic bandage merely gives mechanical support to the dilated varices by holding their walls collapsed or compressed to their normal size. Two: Injection of sclerosing solutions in the blood vessels. The object of producing thrombosis was first employed in 1851 by Pravaz. Sodium morrhuate in one to two cc. doses has been most widely used. Very few systemic reactions are encountered. McPheeters¹¹ believes reactions occur when too large a quantity of the solution has been injected into one varix of the calf. He advocates the use of a tourniquet to localize the injection solution, thereby to retard the rate of absorption and minimize the allergic response. Occasionally a varying degree of shock is encountered. It may vary from a fainting spell to surgical shock. It is well to give the patient a preliminary test dose, twenty-four hours in advance of the actual

therapy. Injection of a small amount of sclerosing solution of a test dose suffices to reveal the necessary information. It is considered that .5 to 1 cc. of a 5 per cent solution of sodium morrhuate injected into a varicose vein of medium size is a sufficient amount. If a systemic reaction occurs, the likelihood of minimal manifestations may be expected if small amounts are used. The prompt administration of an appropriate amount of epinephrine hydrochloride will adequately control this emergency.

OPERATIVE PROCEDURE

The site of the varices is marked with brilliant green, in order that they may be identified after surgical preparation.

One per cent novocaine is the anaesthetic of choice. In surgical procedure for varices during pregnancy it produces the least amount of general reaction. A small skin incision is made over the fossa ovalis parallel to the inguinal ligament. It is then carried through the subcutaneous fat. The five tributaries; the superficial circumflex iliac, superficial epigastric, external pudendal, lateral superficial femoral, medial superficial femoral, as well as the other accessory veins are divided between forceps and then tied. The saphenous vein is cut between forceps and the proximal segment is doubly ligated at the sapheno-femoral bulb. The distal segment is doubly tied at the lowest point in the incision. The subcutaneous fat and skin is then approximated. The author prefers fine cotton sutures for the approximation. The segmental ligations are then done. Small one-to-two-inch skin incisions are made and the veins divided between forceps and tied. The skin is then approximated. Dressings are applied and number eight ace bandages are wrapped from the toes to the groin. The patient begins to ambulate immediately. The sutures are all removed within one week and in the second week injections of the residual varices is started.

ANALYSIS OF CASES

Thirty patients have been carefully selected for this study, twelve of whom gave a history of having relatives who had suffered from varicose veins either before or during pregnancy. Eighteen, or 60 per cent, denied any hereditary history. Ten per cent, or three patients, were primi parous. Seven had two children; twelve, or 40 per cent, had previously had three children, and 27 per cent had over this number. Of the 30 patients treated, eight had both vulvar and leg varicosities; 22 had leg veins. The most interesting feature of this study was the period of pregnancy during which the symptoms were first noted, that is, ten, or 30 per cent, first complained during the first month of

pregnancy; and ten, or 30 per cent, during the second month; and nine cases during the third month. Thus the majority of cases complained of symptoms long before the weight of the uterus could exert any pressure on the external iliac vein or its tributaries. Five patients were between twenty and twenty-five years of age; eight patients were between twenty-five and thirty years; ten patients were between thirty and thirty-five years; and seven patients were between thirty-five and forty years.

It is also interesting to note the time when the operations were performed. Five of the patients were operated within the first three months, four in the fourth month, nine in the fifth, five in the sixth month, one in the seventh month, and six, three to five days after delivery. Perhaps they should not be included but the veins of this group were followed during their pregnancies.

The author has attempted to chart the severity of pain these patients experienced against the grade of varicosities present, realizing it is quite difficult to evaluate pain. The chart will show three patients with grade III varices who had no pain; one patient with grade II veins had a mild 1 plus pain; one with grade II veins had grade II pain; eight patients with grade III veins had grade II pain; twelve patients who had grade III and IV varices had rather severe pain; three grade IV varices had severe pain.

All of these patients were sedated with grains $1\frac{1}{2}$ seconal the night before the operation and a similar dose two hours before they were taken to surgery. They also received morphine sulphate grains $\frac{1}{6}$ and atropine sulphate grains $\frac{1}{100}$ forty-five minutes before the operation. The operative procedures were carried out under local anaesthesia of 1 per cent novocaine following which the extremities were bandaged with No. 8 Ace bandages from the toes to the groin. The patient is instructed to get out of bed upon returning to his room and walk frequently. Twenty-four hours later he is dismissed from the hospital with instructions to walk frequently and return to the office for after-care.

TYPES OF OPERATIONS

One patient had a high right saphenous ligation. Nineteen received a bilateral combined high saphenous and segmental ligation. Three patients had a right high saphenous and segmental ligation and three others were ligated on the left side. One patient had had a previous bilateral high saphenous ligation and it was only necessary to do segmental ligations. Three patients had a very radical high saphenous, segmental and vulvar ligation.

The author feels very definitely that the proper postoperative care is equally as impor-

tant as a well-executed operation. The patients are followed for a period of at least one year receiving injections of two cc. of sodium morrhuate to alternate legs at weekly intervals for eight weeks, and thereafter, every two or four weeks for the ensuing year. This varies according to the number of residual varices following the operation. Furthermore they are instructed to return for follow-up care through any future pregnancies. Three patients in this series have been followed through subsequent pregnancies. One delivered and required only three injections of sodium morrhuate during the entire period. Another had a miscarriage at three months and is now pregnant again. The third is now seven months' pregnant and has required but a few injections. There were no wound infections and the average hospital stay was 3.3 days. One patient had a few Braxton Hicks contractions several hours after the operation which were controlled by a hypodermic of morphine. Another patient delivered a congenital anencephalic five months later which could not be attributed to the operation.

SUMMARY AND CONCLUSION

The patients must be carefully selected as this is not a procedure recommended for all pregnant women with varicosities. A short review of the literature as well as the anatomy, etiology, and pathology is given.

The importance of the Trendelenburg, Perthes, Ochsner, Mahorner double tourniquet test, Pratt double bandage, and the bandage test is stressed to identify the varicosities.

Treatment consists of three types: one, the conservative elastic bandaging of the legs during pregnancy; two, the injection of the varicosities; and three, the combined high saphenous and segmental operative ligation of the varicosities.

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The Rorschach Test in Clinical Psychiatry

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IT has been a matter of only a few years that the psychiatrist has had the help of psychologists in the evaluation of personality disorders. Prior to this time, diagnosis and determination of underlying psychological functions depended on the psychiatrist's evaluation of the patient's symptoms (what he said) and behavior (how he acted). When the psychiatrist was experienced and also highly intuitive, he frequently arrived at very accurate conclusions, but there always remained questions which could not be answered merely by observation and intuitive interpretation alone. At best, there were subjective elements in the psychiatrist's* conclusions¹ and these permitted considerable error from time to time, both as to correct clinical syndrome diagnosis and to underlying conflictual material.

Behavior, whether in health or disease, reflects the final and complex integration of many underlying psychological factors. Because behavior can often seem to appear very similar, if not identical, in widely different psychiatric disease processes, any test that reveals objective information about the intellectual and emotional status, contributes something very fundamental about any clinical problem in question.

The Rorschach Inkblot Test does this, and therefore it has become the most important single psychological test now in use. As Rapaport and Schafer point out, "The use of the Rorschach Test, as one in a battery of tests, in a clinical-psychiatric setting for purposes of diagnosis and appraisal of adjustment, shows that it is beyond doubt the most potent single diagnostic instrument clinical psychology possesses."²

THE RORSCHACH TEST

In order to understand why the Rorschach Test is such a valuable clinical tool it is necessary to examine the rationale back of it. The test employs the mechanism of projection, which involves the principle that in everything we perceive there is not only the object which is seen but something of the one who sees it. "To the cobbler all things are shoes" is an adage

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*Alexander points out that "if you observe another person, you note his external behavior, but you also know from your own introspective experience what you feel when you behave similarly and use the same facial expression, words, movements, as the observed person does. You understand the other person's motives because you know your own reaction in a similar situation."

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which expresses the idea fairly accurately. Let a child look at a tree and he will think of it in terms of its shade, but that same tree would be perceived in totally different fashions by the artist, the botanist, or the lumberman. Each one would perceive it through his own personal and peculiar spectacles. This would be true of any object perceived by different personalities, no matter what that object is. Our own experience and needs drive us to see the world as we do, and conversely the way we see the world reveals something of our own personality make-up. Since every perception is a product of both the stimulus and the observer, the Rorschach inkblots will be interpreted differently by varying personalities.

The less definite the form of a visual stimulus is the more the observer will have to project himself into his perceptions, since the stimulus itself offers little suggestion. For example, if one were gazing into a fog or a glowing fire, both of which are comparatively formless and unsuggestive, one may see various shapes and forms; but whatever one does see will be one's own projections since neither the fog nor the fire has any specific shape or form of its own. On the other hand, if one looked at the picture of a house there would be little of oneself projected into the perception. The stimulus would be at a maximum since the shape of the house is definite and allows little room for fantasy or mental imagery in its perception. The Rorschach blots lie somewhere between the fog and the house, since it is a partially structured visual stimulus which is suggestive to the patient, but not so definite that it prevents him

from projecting a great deal of himself into what he sees.

NATURE OF TEST

To make an inkblot one simply drops a blob of ink on a piece of paper and then folds the paper over. The result is a virtually symmetrical blot which is only partially structured and which is therefore vaguely suggestive to the subject. Herman Rorschach,³ who was the superintendent of a mental hospital at Berne, Switzerland, made a thousand of these blots and then selected the ten which are now in use because they were the most helpful in revealing the personality of his patients. Five of the cards are colored and five are uncolored. Two of the colored cards have on them a bright red and the last three are in pastels. Of the uncolored cards one is almost black and two are heavily shaded.

The person may respond to any of several characteristics of the cards. He may respond to the whole blot or to any part of it. He may use only the outline, when, for example, the blot is interpreted as an "airplane" or a "crown". Or the shading may be seen as a "cloud", a "bear rug" or a "scene from an airplane". Color may attract him and the bright red often elicits a "fire" or "blood" response. It just so happens that the symmetry of the blots makes it easy to see animals but not so easy to see people. The patient may see animals and humans either moving or still. All kinds of objects may be seen, anywhere from "garden shears" to "violins".

PATTERNS ANALOGOUS TO CLINICAL SYNDROMES

After Rorschach made his blots he was curious to see what various groups of people would do with them. Rorschach's father was a painter and perhaps he had observed that not only did people paint different things but they painted things differently. He presented them first to a large group of normals and found how they reacted to form, color, and movement. He was amazed to find that he could set up a pattern into which all his normals fell. Next, he presented the blots to mental patients: manic-depressives, organics, schizophrenics, and neurotics who were in his hospital, and found that certain types of responses are consistent with clearly defined clinical syndromes. Rorschach found that he could accurately describe and classify a patient by giving him this test even though he had no other knowledge of him.

FACTORS USED: A. AREA

Let us consider first the patient's approach to the test. The blot may be compared with any problem situation in life which is totally new to him. Nothing in the examiner's instructions gives the patient any hint as to how to proceed; consequently he will be forced back on his own manner of dealing with unexpected problem situ-

ations. Let us suppose, for example, that a major catastrophe has just occurred in the life of the patient—the baby has swallowed lye or his wife has gone off with his best friend. Just what will he do in such a crisis? We should expect the normal person to take a survey of the whole situation and then to do what was obvious and practical. If this is our subject's way of coping with real life problems he will do the same thing on this test; i.e., he will interpret the whole blot first and then attack the larger, more obvious divisions of it. He will do this because it is his habitual manner of tackling problems. But many of our patients do not handle crises in this fashion; they run away from the major problem and fuss around with trifles. In the same way, our anxious patients make no attempt to interpret the entire blot, but run away, figuratively, by interpreting tiny details around the edge. On the blot, as in life, the whole situation overwhelms them so that they are compelled to ignore it and to expend their energy on that which does not matter.

It is logical to expect the unrealistic and grandiose ideas of the manic to be translated into poor whole responses. On the other hand, we would never expect the meticulous, compulsion-ridden patient to do this. It is illuminating to see them largely ignore the whole blot and to concentrate on the tiny details which they interpret over and over again as though they are never quite satisfied with their performance—which indeed they are not, as we know from clinical experience.

B. FORM

The accuracy of the forms is a potent indicator of the patient's respect for reality. Although the blots are vague, the normal person understands that his interpretations must be geared realistically to the actual form before him. He will not expect to find perfect form in an inkblot but neither will he feel free to depart from it too much. If the subject's thinking is too rigid, as we find it in depressions, we may expect painful accuracy of perception and the complete absence of any freedom with the blot—only dry realism and accuracy being left. The paranoid patient, who has a well-preserved front, reacts the same way but for different reasons. He is evasive, guarded and meticulously careful not to expose his real thinking and feeling. Consequently, he will give extremely accurate forms or see such things whose forms cannot be questioned, such as islands or emblems. The schizophrenic is as unpredictable in his interpretations as he is in life—in one instance giving keen and accurate form and in the next using the material in an absurd fashion. The organic, whose perceptive and associative processes are

impaired by actual tissue loss, will see the forms vaguely and show great perplexity.

C. COLOR

Color induces emotional reactions in all of us: some of us love the cool greens and blues, while others go in for the passionate reds. It must be evident to everyone that the typical Scarlet O'Hara who dresses in flashy colors is a totally different personality from the mousey spinster who retreats in gray. The five colored cards are so interspersed in the series of ten that the patient cannot help but reveal his emotional make-up in their handling. The normal person who is reasonably sociable ought to be stimulated adequately by color and give a certain percentage of his responses to the last three colored cards; on the other hand, we should expect some patients to withdraw from emotional situations or to avoid them. We should not expect a depressed patient, for instance, to respond to color, since to him life is dark and gloomy; we should rather look for him to reduce his responses on the color cards and to concentrate on the heavily shaded ones. This he does. The smoldering, pent-up emotions underlying the depressed condition may be glimpsed by the occasional injection of impulsive color—often the danger signal of a potential suicide.

We expect the normal person, in spite of his emotional stimulation, to temper his reaction with intellectual control. Both the normal person and the obsessive-compulsive whose maladjustment is intellectualized will respond to color, but only if the form is good. In other words, consideration for reality, which is represented by accuracy of form on the inkblots, will temper the emotional response. While the neurotic avoids the color or hesitates to use it, the psychotic will interpret it unhesitatingly as though it means little to him. Red often is seen as a "fiery sunset" and blue as the "sky above". If the subject is a schizophrenic he may resort to symbolism: "pink for the pink of condition", "gold for kingship", etc. The first evidence of pathological breakdown in the conceptional processes is revealed by the loss of critical ability in such responses as "pink wolves" and "yellow dogs". The normal and the neurotic do not let color considerations enter into responses where they are obviously not apropos, but the schizophrenic sees nothing bizarre in such use of color. Occasionally the complete arbitrariness of the schizophrenic will be revealed when he uses color as the only criterion for association with a total disregard for form—he may see one blue spot which is a good "spider" but then all blue spots become spiders regardless of form. It is as though we should think "all grass is green, therefore everything which is green is grass". Organics who are totally unable to

think on an abstract basis make no attempt to interpret the colors, but name them or describe them just as they describe other aspects of the blots.

D. MOVEMENT

Movement was defined by Rorschach as those responses in which a human form is seen in action or an animal form is seen in typical human movement such as a "bear doing the Charleston". Since there is no actual movement on the cards, all such projections must be the sole creations of the observer and they will therefore serve to measure his imaginative capacity and his general intellectual level. The deeper a depression is the more fantasy will be repressed. Consequently it is possible to distinguish psychotic from neurotic depression, since movement will be absent in the former but present in the latter. The third card is so popularly seen as "two people doing something" that not to see them is typical of disturbance. Evasive paranoid schizophrenics often betray themselves by not seeing the movement on this card and seeing good movement on other cards.

Many psychotics who are given to ideational activity, among them the manics and the paranoid schizophrenics, may see many people in action, but because they are not bound by considerations of reality their form will be poor—a factor which helps to distinguish them from the obsessional neurotics, who are also ideationally active but whose respect for reality holds them to good form.

E. SHADING

The subject may use the shading in two principal ways. First, he may use it as texture and so give an indication of his sensitivity or sensuousness. The very sensuous person may go so far as to feel the card or stroke it and give such responses as "fur" or "sponge". He has responded to texture alone without any intellectual control, and we may expect him in life to surrender completely to his own sensuousness at times.

Opposed to texture are the other aspects of shading, those which arouse the anxiety of the patient by the general darkness and gloom. Normal individuals who do not give way to panic may see "clouds" and "smoke rising" but there is always the element of intellectual control in the form perceived. The patient who gives way to uncontrolled anxiety in life may give such responses as "horrible witch's atmosphere" or the "gloom of night". No form is involved and by the same token no intellectual control governs him when he is attacked by panic in life.

SEX CONFLICTS

Sexual conflicts are easily detected by the cards. Two of the three sex cards are dark

and the colored sex card is diffuse and disturbing. Homosexual strivings which may be suspected by the psychiatrist are frequently revealed in the Rorschach Test. The patient is often unable to distinguish the sex of the figure—sometimes he says quite frankly that he cannot tell whether it is a man or woman; he may give significant symbolic responses, dehumanize his people, and show revulsion for the opposite sex.

Other sex disturbances are seen in perseverative "pelvic" responses, the inability to leave the phallic details alone, or the giving of sensuous food responses in the sex areas. When the phallus unconsciously is conceived of as an aggressive weapon of destruction, the projections on the blots will be interpreted as guns, swords, etc. If such imagery is combined with impulsive color, pure texture responses, and low intellectual control, we may safely predict unfortunate sex conduct.

THE CLINICAL CONTRIBUTIONS OF THE RORSCHACH TEST

With the evaluation of every patient, one is concerned not only with the diagnosis but even more with the changes in psychological functions.⁴ Impairment or preservation of certain psychological functions can be correlated with certain mental disorders. Disturbances in mental functioning can often be demonstrated on the Rorschach Test before any clinical evidence of this disturbance may appear, thus not only aiding in early diagnosis but also giving the clinician insight into the nature of psychological dysfunctioning.

Information obtained from the Rorschach Test can be used in different ways by the clinician. It certainly is helpful in determining the treatability of a patient, because where there are conflict and introspective capacity, as reflected in good movement, one may be certain that treatment efforts are justifiable. On the other hand, even though clinically a patient may not seem very sick, yet the absence of conflict and a capacity for introspection would make the prognosis guarded and treatment difficult.

The psychiatrist is always concerned about the possibility of impulsivity with either internally or externally directed aggression. Such potentialities are clearly revealed on the Rorschach record, and therefore the clinician is helped in devising a treatment and supervisory program.

Case examples might be given where the findings on the Rorschach Test were invaluable in the appraisal of the patient. However, we are sure all of you have witnessed this fact. So, to summarize the clinical contribution of the Rorschach Test (and its allied psychological tests) we would like to quote Menninger⁴ and his associates: "The systematic and intelligent

use of tests in psychiatry should yield extremely fruitful results. The employment of these test methods should not only lead to a greater proportion of correct and timely diagnoses, but in addition they can be utilized in an experimental way to investigate an important aspect of ego-psychology, namely, the nature of human thinking.

"As a practical matter this is now working out as follows: psychological testing has revealed the presence of a schizophrenic process in many patients, while clinical evidence of schizophrenic tendencies is faint or absent. To put it another way, the psychologist is discovering schizophrenia or 'potential' schizophrenia or 'latent' schizophrenia in patients who are not suspected of being classifiable as schizophrenic according to old concepts and which have puzzled the psychiatrist diagnostically and therapeutically. This is not happening in a few cases, but in a considerable number of cases, enough to make us suspect that the vast majority of persons in whom a 'schizophrenic process' is present are not easily recognizable as such without specific testing. It may be indeed that it is only the exceptional schizophrenic who comes to the psychiatric hospital for treatment, and it may be again that many persons whom we have called 'alcoholic addicts', 'psychopathic personalities', 'intractable neuroses', and so on, must be viewed in a very different diagnostic (and therefore therapeutic) light."

Our concepts of psychiatry and mental disease processes are changing and enlarging. For this change we psychiatrists owe much to the clinical psychologist who is doing so much to help us gain a better understanding of psychological functions and disorders. It was a great step forward when psychologists and psychiatrists started to work together as a team.

SOME LIMITATIONS ON THE RORSCHACH TEST

In closing our paper, we would like to point out some limitations of the Rorschach Test and emphasize the fact that it is the most valuable when it is used as part of a battery of psychological tests, as Rapaport and Schafer have indicated.²

The Rorschach Test is not an infallible tool. It has at least three rather serious drawbacks, as the authors see it. First, although the dynamics are usually validated by therapy or the case history, as a diagnostic tool it often overshoots the mark. That is, the record may indicate a more malignant disorder than the clinical picture presents. It is true that usually the clinician agrees that if a more serious break came it would lie in the direction indicated, but the break may never come. Two records may almost parallel each other in nature of responses given, but one patient may be making an ex-

cellent adjustment while the other is still in need of hospitalization. The control factors on the Rorschach Test need to be more clearly understood.

The second difficulty is that there are some records which can fool the examiner if he has not had much clinical experience. The form level, for instance, is one of the most reliable scores on the test for estimating a person's contact with, and respect for, reality. Records in which the forms are necessarily rather indefinite, i.e., when the patient gives nothing but islands, emblems, etc., may result in a high form level but actually it is often a picture of psychotic evasion. In such cases the Rorschach Test alone will not be sufficient as a diagnostic tool but a supporting battery of tests will be needed—principally a concept-formation test.

Finally the Rorschach record is only as good as the examiner makes it. It is a difficult instrument to learn to use well and requires much skill. Even though the examiner may base his interpretation largely on statistical norms and formulae, the fact remains that the Rorschach Test is a personal instrument. Therefore, the examiner must be well trained in the use of the blots; he must have a broad clinical experience, be well versed in philosophy and abnormal psychology, and have a great deal of intuition.

In spite of these rather high requirements for the examiner himself and the other limitations mentioned, the Rorschach Test is still the most single valuable psychological test in use.

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Antibiotic Sensitivity

In our opinion, based upon experiences in several laboratories now routinely performing the various procedures accompanying antibiotic therapy, the serial dilution technic may be employed to greatest advantage where a relatively small number of levels and sensitivities are run (several tests per week). If, on the other hand, the laboratory is called upon to perform many more tests routinely, the plate technic is desirable. To determine antibiotic sensitivity of a greater number of organisms isolated from infective processes, it is simpler and less time consuming to use the streak plate technic.—E. E. Vicher, Ph. D., and S. A. Levinson, M. D., Chicago. *The Illinois Medical Journal*, Vol. 93, No. 3, March, 1948

KEEPING UP WITH MEDICINE

- AN adequate program for teaching home nursing would greatly reduce the "overlapping" in medical care of the hopelessly ill. The family physician can do as well as any specialist but failure to understand the nature of the illness sends the patient and his family from one specialist or one clinic after another, thus greatly adding to the cost of medical care.

* * *

- WHEN the cancer cell of the prostate is deprived of its supply of male hormone it undergoes a temporary regression, but finally it develops again into a killer in spite of its feminized environment.

* * *

- THE American Dental Association has gone on record as favoring the use of topical applications of one and two per cent solutions of sodium fluoride to the teeth of children—especially to newly erupted permanent teeth—for the prevention of significant amounts of dental caries.

* * *

- No antibiotic can replace antitoxin in diphtheria, but when antitoxin is combined with penicillin, organisms may be eliminated from the throat more quickly.

* * *

- AUTONOMIC nervous system imbalance which may cause ulcer or delay healing must be corrected by control of emotional disturbances and complete prohibition of tobacco and gastric irritants. The fatigue factor must be eliminated and habits of hygienic and unhurried living established.

* * *

- THE possibility of pancreatitis must be considered in cases in which the patient continues to have attacks of pain simulating of biliary colic after cholecystotomy has been performed.

* * *

- Now comes Science and those who think that by the artificial cultivation of the powers of bodily resistance they shorten by thousands of years the long path to abolition of the deadliness of our enemies. Maybe we ought to begin the decentralization of our hospitals to the rural areas for at Hiroshima there were 150 physicians of whom 65 were killed outright and most of the others were so badly injured that they were unable to treat others. Of 1,780 nurses, 1,654 were killed or hurt too severely to carry on. Figures of physicians and nurses are all out of proportion in the ratio to the population. I submit these figures for what they are worth to the profession in Toledo, Cleveland, Akron, Canton, Massillon, and Youngstown as key cities in the heavy industries; to Columbus because of the importance of its reserve depot; and to Dayton as a center of aviation.—J. F.

Whence Came You?

FRANK A. RIEBEL, M.D.

NOTE:—Evolution is easy. At least down to microscopic magnitudes and back to the one-celled organisms. What happened before? What happens smaller? In the belief that the cultured physician would like to know, the writer has attempted to extend in these two conceptions of time and space, omitting the mathematics on which these modern beliefs are erected.

IN the beginning the universe had a radius of about three million miles. That's all. Our visible universe, which is now at least 500 million light-years across, was condensed into that relatively tiny area.¹

How is that possible? By compressing, or rather, antedating the atom, which now—between nucleus and electrons—is more space than substance.

When was all this? The creation of our universe dates back rather accurately to between two and three billion years ago. Several calculations cross-check on these calculations, of which we will mention two.

Astronomers have known for a long time that we are in an expanding universe. In other words nearly all the celestial bodies are flying away from us and the rates that they are flying away are known. Reasoning backwards, simple calculations tell us that all the stars had a central starting place between two and three billion years ago.

We also know about the origin of the universe from the activities of certain radio-active materials. For instance, the two kinds of uranium are always found together in fixed proportions. U-235 which is decomposing into U-238 now comprises about seven tenths per cent of the mixture. As the rate of that decay is known it is easy to calculate that the original unstable uranium was created about three billion years ago.

This original universe was made up of a primordial fluid of a terrific density to a degree of about 10^{14} grams per cubic centimeter. Perhaps it was pure neutrons.

Now we know from the studies in connection with the atomic bomb and other research before that that elements originate under conditions of extreme pressure and extreme temperature. These two essentials did exist back at the remote period of time.

We know that such conditions exist today in the center of the various stars, where the temperatures seem to stick rather closely around 20 million degrees centigrade and the pressure around 160 billion atmospheres. Only under

The Author

• Dr. Riebel, Columbus, Ohio, is a graduate of Ohio State University College of Medicine, 1925; diplomate, American Board of Radiology; on hospital staff, White Cross Hospital.

such conditions can we have the alchemy which changes hydrogen to helium and gives us our heat and light from the sun and stars.

It is also interesting and important that the per cents of the various elements remain rather constant throughout the earth, solar system and stars. How did this happen? It has been shown that the present proportions of the elements in the first half of the periodic system can be explained by the conditions of eight billion degrees temperature, the pressure of 7×10^{18} atmosphere, and the density of 10 billion times the density of water. (The theory is off for the second half of the periodic system since their transformations require much higher temperatures, which suggests that these elements might have occurred at an earlier state of expansion; and also that their proportions might have been disturbed by collisions with neutrons.) At any rate the universe at that remote instant of time went off with a bright bang.

At this point may we pause to marvel at the vision of the seer who said:

1. In the beginning God created the Heaven and the earth.
2. And the earth was without form, and void; and darkness was upon the face of the deep. And the spirit of God moved upon the face of the waters.
3. And God said, Let there be light; and there was light."

From this point on the development of the solar system is readily grasped, with temperatures and pressures in such tiny masses as the earth quickly dropping off and radioactivity subsiding. A mass in what is now the Pacific Ocean flies off to form the moon, the lightest elements forming a protective envelope or atmosphere to fend off radiation (cosmic rays) still shooting about, and so on.

THE FIRST CELL

Did the first cell drop unheralded into the dead embers of this conflagration? No. We have abandoned the idea that Adam and Eve were a couple who ran about the Near East without navels. Is it not just as naive to think of a single cell as being the headwaters of what

¹Submitted September 22, 1947.

was to become the mill-stream of evolution? Surely much must have gone before.

Here and there we are getting hints of the intersteps. Lepinshinskaya³ reports experiments with fragments of cells, which she found were made up mainly of protein molecules. When she disturbed them in various ways the fragments acted to preserve themselves. On the basis of this and other experiments she concluded that the cell was not the lowest living unit but was an assortment of organic chemicals and that the cell grew in a regular pattern. In short then to produce life we may not need to create a complete cell but only the right chemical combination.

Woodward and Schramm have almost done this for they have succeeded in making a protein molecule containing more than a million atoms, which has all the qualities of hair or fur.

How was this done? Merely by putting certain amino-acids together and leaving them alone for two weeks. The amino-acids carried on the rest of the work on their own initiative.

As a matter of fact, we do know of a more primitive form of life than the cell, and that is the virus, which is something less than smaller cells. It can be obtained in crystalline form and may be merely overgrown protein molecules.

Genes are probably similar chemicals and Newman⁵ has said "the further suggestion might be made that genes and virus-like entities are similar in character, but that genes are tamed or domesticated virus-like particles that have been incorporated into the complex economy of particular cells".

He also thinks "that the first life units to appear on earth were isolated genes".

GENES—THE UNIQUE

Genes (or viruses) have at least two unique properties. First, as we shall shortly discuss, they can reproduce themselves precisely down to the last atom. Secondly, every single atom in the giant molecule has a function. This is a tremendous advantage to the Deity who worked this all out.*

Now, viruses or genes act to preserve their original structure. Stanley⁶ added to or cut off pieces of viruses. Placed in living tissue the newborn viruses were like the original parents,

* This is not true elsewhere in nature. Generally physical laws rest on atomic statistics and are therefore only approximate. If we would calculate the number of atoms in a given volume of gas under specific conditions and then count the atoms we would find an error; if the predicted number of atoms would be 100 the actual number would be within 10 per cent; if one million, within 1/10 of 1 per cent. This is the \sqrt{n} rule.

This \sqrt{n} rule, by the way, points up the necessity for an organism's being quite large. Otherwise the organism could not run in keeping with physical laws. Moreover, if it were not gigantic the heat motion of a single atom would knock the organism about. We actually see this happening under the microscope as the phenomenon called Brownian movement.

not like the physically changed ones. This tendency supplies the need for permanence.

NEED FOR A CHANGE

But if we are to get anywhere on the evolutionary train, there must be a mechanism to provide changes. **

Given a giant molecule, called a gene, which as part of a chromosome has the property of reproducing its own kind with exactitude, what mechanisms are there which could cause that molecule to change slightly? That is, to form an isotope. Two come to mind: heat and radiation.

Now heat, as we all know, can cause chemical change and the more the heat the more frequent the change. So it would be to an advantage if the heat in the cell were so regulated that mutations could occur—and yet not too often; or else a species would extinguish itself in hazardous experiments. And so we see that a stable temperature of say 98.6 degrees has an evolutionary value as well as the many others assigned to it.

Another stabilizing influence on profuse experiments is the principle of quantum mechanics. In brief, this theory dictates a resistance to moderate swings in temperature. Instead chemical changes are made in quantum jumps. External energy in a definite amount must be supplied to change the energy levels of a molecule. Or to put it baldly, to make an atom jump and form an isotope.

This is not all theory. Experiments on drosophila showed that an increase in temperature would increase mutations, especially of unstable genes.

RADIATION DOES IT

There is one method in nature and also a similar one in the laboratory by which heat can be applied to a single gene without blasting the whole cell into oblivion. If an X-ray or cosmic ray strikes the cell and is ionized it will cause heat waves; in a cube measuring 10 atomic distances per side, these can cause an electron to jump. In short a mutation has occurred which will be transmitted to the offspring.

Empirically the agronomists have been doing this in the laboratory for some little time, producing new plants by irradiating sprouts. We physicians have done the same thing by accident, producing wild cancer cells by X-ray burns; and also causing leukemia, which occurs among radiologists eight times as frequently as it does among the general population.

AND WHAT NOW?

Everything is cyclic—even the sciences, and suddenly now we find the chemists and physicists

** The writer knows about teleology. The use of the idea of purpose here is short-hand which allows profound mathematical concepts to be omitted.

nose-to-tail with political science. For atomic research has just about answered the question "What Is Life?" and produced the power to extinguish that life. It is believed that a limited number of atomic bombs—perhaps as few as 500—would make life impossible on earth. Even though we never go so far, a single question should give the physician pause.

How would you like to deal with 50 new hereditary factors of the magnitude of hemophilia?

SUMMARY

Great chunks of the multi-faceted problem "What Is Life" have been hacked away, and transferred from the fields of philosophy and religion to chemistry and physics.

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Cardiac Edema

Our medical fathers and grandfathers would be amused at the contemporary furor over the re-discovery of the effectiveness of the low salt diet in cardiac edema. They knew all about it in the years between 1900 and 1920, when the organic mercurial diuretics were not known. Long before 1900, the Karrell diet, with its four or five glasses of milk a day and a salt content of only 1 gm., was a very potent antiedema regime. Its use for short periods is still a very practical and highly effective discipline for a chronically water-logged individual, but it carries the disadvantage of conveying to the patient the idea that milk is good for him. He cannot understand then why it is eliminated from his later, fuller cardiac diet.

With salt-free bread, salt-free milk, unsalted butter, and a little plain cottage cheese, the chief hazards of the low salt diet are by-passed, provided natural unsalted foods are used as meats, fruits, and vegetables with only a few exceptions such as bacon, ham, beets, kale, celery, spinach, and salt-water fish. Beware of corn flakes, dry cereal, and oleomargarine, and, of course, canned vegetables or their juices. One can easily arrange a palatable and varied diet containing only 1.5 gm. of salt. In case of severe rebellion on the part of an undernourished or anorexic patient, the additional use of 1 gm. of salt daily from a salt shaker at the table is permitted. —L. Leiter, M. D., New York City, N. Y. State Jrn. of Medicine, Vol. 48, No. 6, March 15, 1948.

Initial Symptoms of Pollenosis
At an Advanced Age

Mrs. I. H., who is 85 years of age, has lived in Cleveland, Ohio, for the past forty-seven years. She first noted attacks of sneezing, rhinitis, lacrimation, itching of the eyes, during August and September of 1945. During this period she also complained of bronchial irritation in the nature of a harassing dry cough which was worse at night, and most marked around five or six o'clock in the morning. The cough usually disappeared during the day. She was symptom free until August, 1946, when the above symptom complex returned. This history was confirmed by her son who is a physician. She has five children and nine grandchildren, none of whom have allergic manifestations.

The patient was first seen by me on September 10, 1947, at which time she complained of itching eyes, rhinorrhea, and an irritating nocturnal cough. The symptoms had been present since August 26, 1947. The physical examination revealed the presence of rhinorrhea and conjunctival irritation. The chest was kyphotic, and emphysematous. Scattered wheezes were heard throughout the chest. The respiratory rate was normal; the blood pressure measured 190/100; A 2 was accentuated; there were no murmurs, nor was the heart enlarged. Examination of the nose by Dr. Marvin S. Freeman of the St. Luke's nose and throat staff on October 21, 1947, revealed normal findings.

Complete laboratory and X-ray investigation revealed nothing relevant.

Intradermal skin tests showed the following reactions:

House dust—2 plus	Flaxseed—1 plus
Wheat—1 plus	Grass—2-plus
Kapok seed—1 plus	Ragweed—4 plus

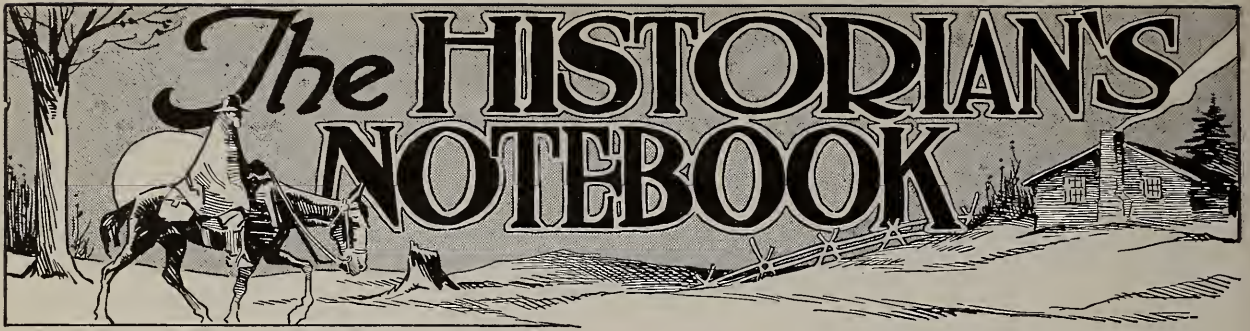
Passive transfer was done with the following results:

Dust—2 plus	Flaxseed—1 plus
Wheat—2 plus	Grass—3 plus
Kapok—Negative	Ragweed—4 plus

Ragweed was insufflated into the patient's left nostril. Within a few minutes the patient began to sneeze; a watery discharge issued from the left nostril; the left eye became suffused; the patient began to cough and became dyspneic. She was given three-eighths grain of ephedrine. The symptoms gradually disappeared having lasted about one-half hour.

It is apparent symptoms due to exposure to ragweed pollen manifested themselves for the first time in a female at the age of 83, who had had yearly exposures for the preceding forty-five years. The history, physical examination, and laboratory evidence preclude any other etiology for her symptoms.

—McKINLEY LONDON, M. D., Cleveland, Ohio.



Ohio Medicine in the Gay Nineties

Part I—1890-1900

JONATHAN FORMAN, M. D.

WE of the Ohio Committee on Medical Archives and History have set ourselves to the task of gathering notes and source material for the era that began around 1890 and ended with the cessation of hostilities in 1945. It seems wise, therefore, for someone to gather a few notes on the American scene and the bearing it has upon the future practice of medicine and upon medical education.

Up until this time the United States Government had proceeded upon the assumption that the regular operations of business and the market place would solve all perplexities. We were still an agrarian people. Suffering now (1890), it is true, from an unassociated horde of immigrants centering around metropolitan areas and from the integration of some 60 per cent of this native born to the same cities. In the meantime, the opening and sale of public lands, the spread of the railroads, the institution of protective tariffs, and the current monetary policies were all furthering the fortunes of our young but thriving Industrial Capitalism. After years of hesitancy, regulating acts were set up to curb abuses and unfair business practices. Increasing pressures finally resulted, in Woodrow Wilson's time, in the intervention on behalf of the less fortunate in the economic round.

We began this era as the model of Industrial Capitalism and changed gradually until in 1945 we began to live in another era—that of State Capitalism. The Machine had proved to be too much for us. To combat it we developed Big Business. This necessitated the formation of Big Labor Unions. These three slugging it out for selfish supremacy compelled full intervention as a basis of public policy on the part of government. It now began Big Government. So to serve and protect "the common man," the Big Four took away his personal rights and

liberty. As we begin to live in the era of State Capitalism, the next step seems clear—State Socialism—and then what? What kind of totalitarianism will follow: How many centuries until man regains his freedom?

In the decade in which we are interested now, we must go back if we wish to get a clear picture of Modern Medicine and read about the first step in the direction of Federal intervention as it came in the regulation of the railroads. Next came the anti-trust laws to regulate the combinations of capital stock of competing companies in trust funds. These trusts had taken over oil refining, cottonseed oil manufacturing, whiskey distilling, and sugar refining. No sooner, however, were these "trusts busted" by court order than the State of New Jersey passed permissive legislation for the incorporation of "holding companies" to replace the trusts (1897). In this epoch came Standard Oil of New Jersey, the United States Steel Corporation, the International Harvester Company, and the American Sugar Refining Company. Because of the popular outcry against monopoly which this legislation introduced, we got the Sherman Anti-Trust Law and the Populist Up-rising.

With the releases of wealth and its accumulation by certain persons came great social cultists. Our newly rich folk built great mansions. It was the age of the jigsaw, the cupola, the mansard roof, and the castle.

"The interiors were no better. Rooms were loaded down with massive furniture of black walnut or golden oak. The tables had jigsaw skirts, the sideboards were rarely complete without the rows of shelves, topped by pointed arches. On the walls, in whatnots, and on top of moldings were statuettes, bronzes, shells, vases, and china and porcelain—all representing the poor tastes of people from all corners

of the world. Men and women overate and overdressed. 'Society' engaged in barbaric displays."

Nevertheless these very things are evidences of social progress. Public education was increasing by leaps and bounds. Americans were going to high schools in great numbers but not yet to colleges. However, the lyceum and the Chautauqua brought adult education to the crossroads.

The evangelical churches played a great role. There was Dwight L. Moody and Ira D. Sankey whose revivalist movement had a great influence in these days. The Y.M.C.A. and the Salvation Army also made their appearance; the first to bring religion to the youths, the second to the poor. The Catholic Church grew in number and power. There was a repetition of the urge the grandparents of these young people had felt in 1830—to become their brothers' keeper—a responsibility which our people have never forgotten, but as their Community Chest, their Red Cross, their societies against Polio and Cancer grew to become Big Business the temptation becomes stronger and stronger to turn the whole business of welfare over to the Social Security Bureau of the Federal Government.

This idea gains momentum from the fact that we set up in our universities, School of Social Administration whose graduates were trained to spend the "conscience money" of the monopolists and the savings of the thrifty. As the features of these philanthropists are disappearing into the jaws of spendthrift government, this army of persons trained to prick the social conscience, naturally follow the money as it goes into the U. S. Treasury, and find themselves on the Federal payroll. But, back in the 90's, philanthropy was just beginning to be modernized. Social settlements were established. The Hull House in Chicago was opened in 1889. Charity organization began to take form and to do yeoman work in the battle against the slums and disease.

As a part of our background we must not forget the development of the modern newspapers, beginning with Joseph Pulitzer and the *New York Daily World*, followed by William Randolph Hearst and the *New York Journal*.

In the meantime, the growth of American Surgery was beginning to suggest the eminence to which it would achieve. At its Nashville convention in 1890 we find the American Medical Association concerned with another form of social regulation—the wider extension of public health activities and the desirability of representation by the public on state boards of health.

In the *Journal of the American Medical Association* for 1892, we find the editor having fun with our Ohio Legislature. It seems that an august Assembly had rejected an appeal to regu-

late the practice of medicine in this State principally because it would interfere with itinerant doctors and diminish the advertising receipts of some newspapers. The Ohio Legislature, however, before adjournment did appropriate \$5,000 to test the Keeley Cure and made itself a committee of the whole to investigate the cure. It was provided that each member was entitled to send one patient to take the cure.

That same year there arose a drive to get the advertisement of proprietary medicines out of the pages of the *Journal of the American Medical Association*. A recommendation which could not even be considered at that time because of the loss of revenue which it would entail.

In the movement to make the American Medical Association a more complex organization on the grounds of offering to remove proprietary medicine advertisements from the pages of its journal, to get lay persons interested in public health, and to give wider power to state boards of health and a place on the Presidential cabinet for a Secretary of Health, we see the stirring of the sound forces that were at work in politics, in education, and society as such. All of this brings out our oft repeated statement that "medicine is always closely woven into the social fabric."

(To Be Continued)

Herbert Eugene Twitchell

Herbert Eugene Twitchell the first white child native to the village, was born in Chatfield, Fillmore County, on March 27, 1855, the son of Dr. and Mrs. Refine W. Twitchell. He began his medical training at the Louisville (Kentucky) Medical College. From Louisville he was graduated in 1877, the winner of a scholarship, and shortly afterward began the practice of medicine in the little village of Darrtown, Butler County, Ohio. In 1882, Dr. Twitchell took postgraduate work at the Miami Medical College, Cincinnati, from which he received a degree, and in 1885 studied at the Cincinnati General Hospital. On April 18, 1886, he opened an office at Hamilton, also in Butler County, where he resided and followed his profession until a few years before his death.

During the Spanish-American War of 1898 Dr. Twitchell was appointed a surgeon of the First Volunteer Infantry of Ohio, with the rank of captain, and so served until the end of the war. In 1915, he was named surgeon of the Central Branch of the National Military Home at Dayton, Ohio, but did not accept the position.

Dr. Twitchell died at the Dayton Military Home on March 4, 1929.—Nora H. Guthrey, Rochester, Minn., *Minnesota Medicine*, Vol. 31, No. 1, January, 1948.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

THE BACTERIOLOGICAL DIAGNOSIS OF PULMONARY TUBERCULOSIS

THE diagnosis of active pulmonary tuberculosis rests on three pillars—symptoms, roentgenology, and the finding of the tubercle bacillus. Of this triad the first two are not specific for the disease; X-ray shadows can only suggest the diagnosis, and symptoms may be vague or appear late in the disease. Physical signs and tuberculin tests have definite but limited diagnostic significance. The demonstration of tubercle bacilli, however, establishes the diagnosis beyond dispute. In this disease, therefore, the laboratory can render a unique service to the physician. It may be more fully utilized if the possibilities and limitations of bacteriological methods are understood.

DIAGNOSTIC SIGNIFICANCE OF BACTERIOLOGIC FINDINGS

The culturing of sputum and/or gastric contents is of paramount importance if a complete diagnostic picture is desired. If frequent and technically expert studies are made both positive and negative results have a diagnostic importance equalled by few laboratory procedures in any disease. Under the conditions just stated, the diagnostic significance of bacteriologic findings may be described as follows:

(1) Tubercle bacilli are demonstrable in practically 100 per cent of patients with frankly active pulmonary tuberculosis. Exceptions to this dictum are: In a considerable percentage of patients with hematogenous disseminations and without cavities, tubercle bacilli cannot be demonstrated for long periods of time. In about 20 to 30 per cent of patients with minimal, asymptomatic tuberculosis, tubercle bacilli cannot be demonstrated with the methods at present available.

(2) Failure to find tubercle bacilli on frequent subsequent examinations in patients who previously had positive findings, strongly suggests that the process has become arrested.

(3) Failure to find tubercle bacilli on at least ten specimens, if all available methods have been used, practically excludes the diagnosis of active pulmonary tuberculosis with the exceptions noted above.

(4) Demonstration of tubercle bacilli in sputum or gastric contents proves, for all practical purposes, the existence of active pulmonary tuberculosis. In rare cases, however, tuberculous lesions occur in the upper respiratory tract (including trachea and large bronchi) which may shed bacilli in the absence of demonstrable pulmonary tuberculosis. Nonpathogenic acid-fast bacilli, which resemble but are not tubercle

bacilli, have occasionally been observed and cultured from human secretions. In case of doubt, acid-fast bacilli must be identified by animal inoculation.

The diagnostic significance of negative bacteriologic findings depends on the clinical and roentgenological picture: In patients with moderate or large amounts of purulent sputum, with obviously active pulmonary lesions, even three or four negative smears and concentrates are a strong argument against the diagnosis of pulmonary tuberculosis. On the other hand, in patients with minimal or no sputum and in whom the pulmonary lesions are small, without cavitation and of questionable activity, negative bacteriologic findings assume diagnostic importance only after many cultures have remained negative.

EVALUATION OF BACTERIOLOGIC METHODS

Under the assumption that competent laboratory work is done, one may expect that cultures of sputum and gastric contents may together contribute between 30 and 40 per cent to the total positive findings. Between 60 and 70 per cent of the new admissions, upon whom a positive diagnosis will be established by the examination of smears and concentrates, will be so diagnosed by one of the first three examinations.

These figures indicate general trends; they are, of course, largely dependent on the type of patients under consideration.

Even with the best available methods it is not possible to demonstrate tubercle bacilli in all patients with active tuberculosis. This is due to technical deficiencies and because some patients expel bacilli only at irregular intervals.

COLLECTION OF SPECIMENS

Sputum: Sputum is collected in sterile wide-mouthed bottles with sterilizable screw-tops. At least 15 cc. should be collected, even if it takes several days to do so. Patients must, of course, be instructed to collect only sputum—that is, secretions coming up from below the larynx, and not saliva or postnasal discharge.

Gastric contents: Fasting gastric contents must be examined in all patients who have no sputum and those in which sputum examinations have been negative. Such specimens must be sent to the laboratory immediately after withdrawal and must be promptly prepared for culture, since prolonged contact with gastric juice seems to impair the viability of tubercle bacilli.—*The Bacteriological Diagnosis of Pulmonary Tuberculosis*, Max Pinner, M.D., *Veterans Administration Technical Bulletin*, October 10, 1946. (Original paper includes laboratory directions and bibliography.)

Brookings Institute Warns Against Federal Compulsory Health Insurance After Extensive Study

RECOMMENDATION that the National Government "keep hands off" in respect to compulsory health insurance was made after an extensive survey of "Medical Care for the Individual" by The Brookings Institute at the request of Senator H. Alexander Smith, chairman of the Sub-Committee on Health of the Senate Committee on Labor and Public Welfare.

"Probably no great nation in the world has among its white population better health than prevails in the United States," the report states in one of its conclusions, adding that "it is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country."

Senator Smith invited The Brookings Institute to undertake the study in May of 1947. Two senior staff members of the institution, Dr. Lewis Meriam and Dr. George W. Bachman, were given the responsibility of the study. The full report of findings is in preparation.

The conclusions and recommendations drawn from the report are presented below as they appear in an extract published by the Institution, with certain portions emphasized:

* * *

ISSUES INVOLVED

Before summarizing the conclusions and recommendations it may, however, be well to enumerate briefly the main elements in the foundation upon which they rest. These elements are:

1. An analysis of the major issues involved in changing existing arrangements for the provision of medical care to individuals. This analysis was made mainly through an extensive examination of the literature in the field.

2. Examination, appraisal, and analysis of the major bodies of factual evidence, mainly statistical, that bear on such of the issues as are essentially questions of fact.

3. Application to many of the issues of the knowledge and judgment gained by the Institution or by members of its staff who have worked on this project through earlier activities. Three particular types of such activities deserve mention:

(a) Intensive studies of government and its administration, including functions, activities, and procedures of the National Government and surveys of State governments and their administrations;

(b) Statistical studies in the fields of population and vital statistics, and in the social and economic problems related to these fields;

(c) Experience in administration and research in the fields of public health, control of diseases, and medical relief. In this connection, however, it should be noted that the present study has been confined to social, economic, and governmental issues, and no attempt has been made to treat strictly medical problems.

CONCLUSIONS

The conclusions based on this foundation are:

1. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogenous countries, such as New Zealand, with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.

GREATER U. S. PROGRESS

2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care.

3. The nonwhites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.

4. The advances in health among both the whites and the nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system.

5. Although the statistics resulting from the administration of the Selective Service Act—the so-called draft statistics—have been widely

used to show bad health among the American people and the need for revolutionary changes in arrangements for medical care of individuals, they are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole.

OUR SYSTEM EXCELLS

6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the Second World War.

7. The conditions in extremely poor rural areas that lack the resources to support adequate public services, such as health work, education, and highways cannot be satisfactorily solved by subsidies. This problem calls for a radically different approach, either bringing in new or improved economic activities or getting the people to more favorable and administratively less expensive areas. This condition has been accentuated by the emigration of youth from these areas to urban communities.

ALWAYS THE INDIGENT

8. The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements.

RED TAPE

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. The problem of eliminating politics from

Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

12. The administration of compulsory insurance would require thousands of Government employees for accounting, auditing, and inspection and investigation.

INCREASED COST

13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency to insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.

14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.

REMUNERATION PROBLEM

15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (a) fee for service, (b) per capita, or (c) salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

RECOMMENDATIONS

1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Government administration. It seems highly improbable that this experi-

mentation—possible under our Federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtless then be adopted with a great degree of unanimity. If compulsory insurance should be adopted now by a narrow vote in the Congress, thousands of persons who are opposed to it would start hostile to the whole undertaking.

SUGGESTED TASKS

2. For the time being the National Government and many of the State governments may well devote their resources and energies to:

- (a) Research and developments in the fields of public health;
- (b) Health education at the school level;
- (c) Teaching of preventive medicine;
- (d) Assisting in the acquisition of physical facilities and training of personnel;
- (e) Providing systematic care for the indigent and the medically indigent. In some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and coordinated program.

VOLUNTARY ORGANIZATIONS

3. From the standpoint of public relations, governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, State, and local voluntary organizations which have been able to enlist the active cooperation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are nonmedical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest, and cooperation of individuals, families, and local communities.

COMMITTEE ON COSTS

These recommendations are not widely at variance with those of the majority of the Committee on the Costs of Medical Care, arrived at in 1932 after a comprehensive study. The report of the committee says:

* * * [The] majority of the committee does not endorse the recommendation which would make health insurance a legal requirement for certain sections of the population. These members realize that such a step may ultimately be necessary and desirable in some States, but they believe that for most States and probably for almost all of them at the present time, it is much more desirable (a) to encourage voluntary measures for protection against wage loss during sickness, and (b) to develop voluntary insurance for medical care in conjunction with group practice, with hospital service, and with the related measures recommended on the preceding pages. They are of the opinion that the difficulties of these plans can be controlled by a combination

of professional and community effort, and that these plans hold the promise of steady extension in scope of service and in proportion of the population served. These members believe that the various payment plans (aside from compulsory insurance) if fully carried out, would: (1) largely solve the problem of hospital costs which constitute about 50 per cent of the average family expenditure for the care of sickness; (2) provide adequately for many rural areas in which serious deficiencies of facilities exist at present; (3) make more nearly adequate provision than exists at present for the "indigent" and for the care of certain diseases of public importance; and (4) provide, through voluntary cooperative insurance * * * medical service to a majority of the 70,000,000 people living in industrial communities and in cities.

CHANGES SINCE 1932

The years since 1932 have witnessed—

- 1. A great growth in voluntary insurance both for hospitalization and for medical services.
- 2. State experimentation with compulsory health insurance in Rhode Island and California.
- 3. A growing willingness on the part of practitioners to cooperate in the development of prepayment plans and other devices to enable patients who so desire to regularize their payments for medical care.
- 4. A profound change in the amount and distribution of the earnings of the American people. This change greatly reduces the number who cannot afford adequate medical care if they desire to purchase it.

The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the majority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress.

Medina Hospital Symposium

The Staff of the Medina Community Hospital is sponsoring a symposium on "Emergencies in General Practice," considered under Medical, Pediatric, and Surgical Divisions, at 2 p. m., Wednesday, May 19, at the Westfield Country Club, LeRoy.

Scheduled to speak are: Dr. J. G. Kramer, Akron; Dr. Edward M. Klein, Dr. B. B. Larson, and Dr. R. M. Hosler, all of Cleveland. In addition, Dr. P. A. Davis, Akron, will present a short address on the "American Academy of General Practice."

Dinner will be served in the evening, followed by entertainment. This is the first symposium sponsored by the staff which plans to make it an annual affair, according to Dr. R. L. Mansell, Medina, chairman of the publicity committee.

When BCG Vaccination Against Tuberculosis Should, Or Should Not Be Used, Outlined in Policy Statement

VACCINATION with BCG does not provide complete protection against tuberculosis and, until further controlled studies are conducted, cannot be recommended for the general population. However, since BCG appears to provide some degree of protection it is recommended for members of groups constantly exposed to tuberculosis if they have a negative reaction to the tuberculin test.

These conclusions are contained in a statement of policy adopted by the Executive Committee of the American Trudeau Society, Medical Section of the National Tuberculosis Association. The statement of policy reads in part as follows and should be of interest to all Ohio physicians and a help to them in answering questions on BCG immunization:

1. BCG vaccine, prepared under ideal conditions and administered to tuberculin negative persons by approved techniques, can be considered harmless.

2. The degree of protection reported following vaccination is by no means complete nor is the duration of induced relative immunity permanent or predictable. The need for further basic research is recognized. Studies should be directed: (a) Toward the improvement of the immunizing agent, (b) to the development of criteria for vaccination and re-vaccination, and (c) to determine more accurately which groups in the general population should be vaccinated. Several well controlled studies are underway at the present time.

3. On the basis of studies an appreciable reduction in the incidence of clinical tuberculosis may be anticipated when certain groups of people who are likely to develop tuberculosis because of unusual exposure, inferior resistance, or both, are vaccinated.

(A) In the light of present knowledge vaccination of the following more vulnerable groups of individuals is recommended provided they do not react to adequate tuberculin tests.

Doctors, medical students, and nurses who are exposed to infectious tuberculosis.

All hospital and laboratory personnel whose work exposes them to contact with the bacillus of tuberculosis.

Individuals who are unavoidably exposed to infectious tuberculosis in the home.

Patients and employees of mental hospitals, prisons, and other custodial institutions in whom the incidence of tuberculosis is known to be high.

Children and certain adults considered to have inferior resistance and living in communities in which the tuberculosis mortality rate is unusually high.

(B) Vaccination of the general population is not recommended at this time except for carefully controlled investigative programs, which, as a rule, will be best carried out under the auspices of official agencies such as the U. S. Public Health Service, state and municipal health departments, and other especially qualified groups.

4. BCG vaccine should not be made available for general distribution in the United States at this time because: (a) the most effective strain of BCG has not been agreed upon nor has fully satisfactory standardization of the vaccine been achieved, (b) the best qualified experts have not agreed as to the most effective method of vaccination, and (c) fully satisfactory arrangements have not been perfected for transportation and storage of the vaccine.

The vaccine should be prepared only in accredited laboratories especially devoted to this task.

Adequate record systems should be devised for management of the statistical problems involved in recording and following large numbers of vaccinated people.

5. The Society believes that since BCG vaccination affords only incomplete rather than absolute protection, the most effective methods of controlling tuberculosis in the general population are (a) further improvement of living conditions and the general health, (b) reduction of tuberculous infection, which can be accomplished by modern public health methods and the unremitting search among presumably healthy individuals for patients with infectious tuberculosis, (c) prompt and adequate medical and surgical treatment of patients with active disease, (d) segregation and custodial care of those not amenable to accepted forms of therapy, and (e) adequate rehabilitation.

It is to be emphasized that BCG vaccination must not be regarded as a substitute for approved hygienic measures or for public health practices designed to prevent or minimize tuberculous infection and disease. Vaccination should be regarded as only one of many procedures to be used in tuberculosis control. Vaccination seems unwarranted: (a) in areas in which the tuberculosis mortality rate is extremely low and (b) in localities in which the tuberculin test is of special value as a differential diagnostic procedure.

Address of the President

RALPH L. RUTLEDGE, M. D., Alliance, Ohio

Delivered on March 30, 1948, Before House of Delegates, Netherland Plaza, Cincinnati

IN this year of chaos and strife, all the major problems of the world that were existent a year ago, still go unsettled. Thank God the Ohio State Medical Association can boast of a better record than that.



R. L. RUTLEDGE, M.D.

from his own observations, might in some small way benefit this organization on its forward march.

At this point, may I pause to thank the House of Delegates of the Ohio State Medical Association for the high gift and trust bestowed upon me when they chose me for the presidency of the Association. It has been a glorious year. You have helped make it such. And, if from here on I use the pronoun "we," more than I, all of you can rejoice with me in that you have one and all been partners in this Enterprise that we have chosen to call the Ohio State Medical Association. My thanks to all, The Council, the Executive Staff, the committees, and each and every member who may have made his contribution to the success of this year's work.

One cannot be associated for ten or fifteen years with the leaders of medical societies in our State without a rich experience, as those men whose names are familiar to all of you have given much of their time, thought, and energy to the upbuilding of this Association. Let us revere the memory of those who have passed on. To those who are still alive, may God give them strength to "carry on" for many more years.

WOMAN'S AUXILIARY

We are blessed by not only a very young Auxiliary but one of the largest in these United States. It has not been so many years ago, eight I believe, and in this same city, that a

few of our beloved wives organized, what seemed to be in the beginning a mountainous task. But, today we stand near the top in point of membership of all the Woman's Auxiliaries in the United States. Someone has wisely said, "Never underestimate the power of women." That is almost a proverb. I have often said that our wives are best exponents of public relations.

Our Auxiliary has grown to thirty-seven chapters with more to be organized in the very near future. During the past year, the *Medical Auxiliary News* made its appearance. Some physicians would be surprised to read in any edition the work that is being done by our wives. It is my sincere hope that every county society will sponsor an auxiliary and entrust it with any good project they want to put over. When that happens the true value of the Auxiliary will be proven. Coordination of effort will strengthen the cause of medicine. An occasional ladies' night will enhance the social program of any county society and will more closely bind the ties of both organizations.

OHIO MEDICAL INDEMNITY

One of our "25 To Keep Alive" projects which was started by your Association in 1945 has certainly proved to be an outstanding achievement. This as you will recall is our "Doctors' Plan," Ohio Medical Indemnity, a voluntary prepaid medical care plan. This was our answer to the New Deal and others who have demanded compulsory governmental health insurance. The medical profession of Ohio was asked by the Ohio State Medical Association to subscribe \$100,000 to initiate our prepaid medical care plan in Ohio. The response was overwhelming. At that time, 2,000 shares of preferred stock were issued at a par value of \$50 per share, a total of \$100,000. This capitalization was necessary to meet the requirements of the insurance laws of Ohio. A provision was made in the Articles of Incorporation for the establishment of a sinking fund to be used for the redemption of this preferred stock as soon as possible.

On Thursday of this week, April 1, 1948, only two years after beginning operation, Ohio Medical Indemnity, with great pride and satisfaction, will redeem this preferred stock. This action is, in effect, the return to the medical profession of the funds so generously lent to launch Ohio's prepaid medical care plan. Also, it will permit

Ohio Medical to enlarge and expand its benefits to subscribers.

Ohio Medical Indemnity is able to take this action because of its phenomenal growth and progress. As of this date, we have a total enrollment of 345,000, approximately 250,000 subscribers having been added in the past year. As you know, we operate under agreements with the Blue Cross plans and now we have contracts with the following Blue Cross Plans: Akron, Canton, Cincinnati, Columbus, Toledo, Youngstown, and Lima. Coverage is now available in 82 of the 88 counties of the State.

VIEW OF THE FUTURE

It takes "plus effort" to meet the exacting demands on a good doctor. Under political medicine, doctors fear the top rewards would go not to the men who make "plus" efforts in their profession, but to those most compliant toward the reigning political regime. Therefore, we must continue to oppose compulsory health insurance schemes, all of which would be political in character.

Hospitals must be made more accessible to rural people, and likewise, more doctors must be located in rural areas. How are we in Ohio planning to meet these problems?

First, our Ohio Department of Health has been provided with Federal grants-in-aid for the next five years totaling \$13,000,000. This will be known as the "Ohio Hospital Plan," a plan for the development of a coordinated and inter-related hospital system throughout Ohio. Local communities will have to supply two thirds of the costs of hospital construction, the Federal government putting up the balance.

HOSPITAL SURVEY AND PLAN

The Hospital Facilities Unit within the Ohio Department of Health has conducted an inventory of existing hospitals, surveyed the need for the construction of hospitals, and will develop and administer the state plan for approved hospital construction. A Hospital Advisory Council has been appointed and will function as a consulting group to the department in matters relative to policy. On January 29, 1948, the Hospital Advisory Council held its first meeting and officially approved the Ohio plan. It subsequently was approved by the Surgeon General of the U. S. Public Health Service. The plan takes into consideration also the development of public health centers and auxiliary units. It is based on data recently collected and meets the requirements relative to the planning as set forth in the Federal Hospital Survey and Construction Act. The plan emphasizes the need for construction of hospital facilities in rural areas with small financial resources. High priority is given to areas which

show no acceptable existing facilities. Other factors considered are: Effective buying power, ability of the area to maintain and operate facilities created, and distance from nearest existing general hospital of 50 beds or more.

MINIMUM REQUIREMENTS

In accordance with the Federal Hospital Survey and Construction Act, minimum requirements have been set forth for areas of different types, i.e., base, intermediate, and rural. Three base areas have been designated. Each base contains a teaching hospital of a medical school, this hospital having a complement of 200 or more beds and each area has a total population of more than 100,000 persons. Eighteen areas have been designated as intermediate areas. Each intermediate area contains at least one general hospital with a complement of 100 or more beds and has a total population of more than 25,000. Fifty-three rural areas have been established.

Insofar as practicable, the plan was developed in relation to the proportional need for each of the five major categories of hospital facilities, i.e., general, mental, tuberculosis, chronic disease, and health centers. In determining relative need, consideration was given to existing facilities and those under construction without assistance of the Federal Hospital Survey and Construction Act.

Communities now showing priority rating, plans, contracts, and with two thirds of the necessary funds in hand will share in a distribution of \$2,692,125 of Federal funds now available through your State Health Department. Over a five-year period, \$13,000,000 will be allocated.

Now what has this done? It has stimulated 57 or more communities in the State to seek funds to aid in establishing needed hospital beds. It has made thousands of citizens hospital minded to the extent that they have collected more than \$50,000,000 by bond issues, hospital campaigns, gifts, etc., for local hospital construction.

It was interesting to note that at the first meeting of the Hospital Advisory Council over 200 persons attended from all over the State, representing 57 communities all ready to go on a program of hospital building. Some delegations even had their architects with them, as well as their plans. Yes, some had even the bankers of the community with them to certify that the money was in the bank.

Such enthusiasm on the part of these people certainly sold me on the idea that we in Ohio are ready to go. However, it is just not as easy as pushing a button or turning on a switch.

NEED FOR MORE PHYSICIANS

Alas! There are a couple of other things that will be necessary if we are to have a well-

balanced health program in all areas. We will need more doctors and many more nurses.

The Ohio State Medical Association, through its Rural Health Committee, has made a valiant effort to recruit medical personnel for areas where doctors are urgently needed. Interesting to note, at the first meeting of the Hospital Advisory Council there were 17 communities bordering the eastern, southern, and western state boundaries, really rural areas, with community populations of 5,000-10,000 or less, which were really in there pitching for assistance.

It is in these districts where we are going to have most of our difficulty in providing not only hospital beds and diagnostic centers, but doctors and nurses to do the work. The Committee on Rural Health has (1) sought the co-operation and advice of the deans of Ohio's three Schools of Medicine, (2) sent questionnaires to third and fourth year medical students, interns, and residents asking where they intend to practice and why. Slightly over 80 per cent indicated that they intend to enter urban practice upon completion of their formal education, while 14 per cent plan to practice in rural areas.

A total of 591 future doctors of medicine participated in this survey and stated their views on the problems of finding country practitioners and some offered opinions of their own regarding methods which may be used to deal with the issue.

REVIEW OF SURVEY

The primary reason given for the overwhelming preference for city practice was the lack of facilities, including hospital, diagnostic and consultative aids in rural territories. Of those who favored urban practice 32.8 per cent gave this reason. In 30 per cent of the replies the main factor of choice was the fact that rural practice would preclude the pursuance of a specialty. Of the remainder, 22.8 per cent were influenced by the desire for urban life and culture for themselves and their families.

Of those who chose rural practice, 50 per cent indicated a preference for rural life, one half of this group having backgrounds of rural life. About 25 per cent cited the need or opportunity as the reason for their choice. Most enthusiastic response came from a question regarding the feasibility of an externship with a rural physician as an extra curricular part of medical training conducted under the supervision of medical schools. About 400 said that they definitely desired this as a part of their education. Some doubted the time or ability of the average rural physician to engage in the project, but most of those surveyed thought that the time would be well spent as an opportunity to learn "the art of medicine." Others

commented that the answer is to get more rural boys into medical school, subscribing to the theory that those who are reared in a rural community are most likely to locate in such a community.

A revamping of medical school curriculum was suggested by several of the men. There was apparent dissatisfaction on the part of a number of those who wished to enter the general practice of medicine as to the material offered by various medical colleges. These institutions were blamed by some for leading the students toward the specialties. These men wanted to know more about the diagnosis and treatment of the common diseases and routine office practice.

COMMITTEE'S RECOMMENDATIONS

At a recent meeting of the Committee on Rural Health, the ability of graduates of rural high schools to meet competition in premedical and medical schools was discussed. A study is to be made to determine what percentage of students from rural high schools meet with difficulty in college and medical school, especially in the sciences necessary in medical training.

The committee asked that the deans of the three medical schools in Ohio be requested to furnish information as to the origin of members of the present freshman medical class with regard to rural and urban classification of origin. It was also suggested that a series of lectures on the advantages and disadvantages of rural medical practice be recommended to the deans of Ohio's three medical schools.

In line with the results of the above survey, the committee made the following recommendations to The Council:

1. That the subsidization of rural physicians to encourage them to establish a rural practice should not be undertaken.

2. That a study be made of the feasibility of establishing some type of rural scholarship in medicine for boys with good backgrounds, from rural high schools. If such a scholarship be established, no obligation as to repayment of the money or specification as to type or area of practice should be included.

3. That the attention of medical educators be directed to the revamping of medical school curriculum, and to include more about the diagnosis and treatment of the common diseases and routine office practice; and that medical schools give greater attention to this problem; also that this matter be brought to the attention of hospitals in the training of interns.

POSTGRADUATE EDUCATION

So much for the early medical education.

Our intensive instructional courses offered at these last two Annual Conventions have met with unusual success and will be continued as

long as they serve a useful purpose and continued attraction for our members.

Regional Postgraduate Days have increased in number and in quality over the State in the past year. Your Association did not sponsor a central postgraduate program planned by your officers and executive staff. The success of local sponsorship was so outstanding that these same societies should repeat their postgraduate days, in fact many have already expressed that intention. That to me is a healthy state. More power and success to them.

NURSING EDUCATION

A critical situation prevails over the State in nursing education and the supply of nurses. Many believe nurses' training should consist of a good high school course of four years and three years of training in an approved school of nursing. I think this would be a satisfactory basis standard.

We should give encouragement to our small nurses' training schools. Without them the larger training schools would be handicapped, as the larger postgraduate colleges would be without the graduates of the smaller colleges. We should realize that the smaller hospitals seriously need the nurses' training schools. Out of each class we always find one or two who are capable of graduate training who should be encouraged and financially assisted to a good postgraduate education. I never want to see our present standard of registered nursing lowered by substituting a corps of workers known as "practical nurses" to do a job that neither you nor I would regard as satisfactory.

Miss Ella Best, executive secretary of the American Nurses Association, recently answered a statement made by Dr. Morris Fishbein, editor of *The Journal of the A.M.A.*, in *Hygeia*, in which he suggested that the training of more practical nurses might remedy the existing national nurse shortage. She said:

"May we respectfully suggest that the solution of the nursing crisis does not lie in the training of more practical nurses to take over the major part of bedside nursing in hospitals, as you were quoted in *Hygeia*. We recognize that practical nurses fill a needed function but not this one. This step would be extremely detrimental and dangerous to a patient's welfare." She added that in the time of the critical shortage of doctors, it was not suggested that first-aid technicians be substituted in their place.

Larger nursing schools have tended rapidly to center on education for those who are to become supervisors, hospital and school administrators, industrial nurses, and public health nurses, and the direct care of the sick has become a minor interest. The medical profession,

the hospitals, and the sick patients demand adequate nursing care. It can be given. Years of higher education are not required to supply it, in spite of the unwise aims of national nursing bodies and super-duper training schools. Someone has to do the work. The nursing army cannot be made up entirely of five-star generals. We have to have the vast majority of the good old "buck private," or run-of-mine R. N. to win this war known as the National Nursing Shortage.

TOO MANY SPECIALISTS

Is this not analogous to the position of the medical profession? Too many physicians want to be specialists. Too many refuse to make house calls or night calls. Someone has to do this work or the tradition of American medicine and American nursing will be only a memory. We will awaken someday to a situation like that which confronts our colleagues in Britain, where chaos and socialization are threatening.

VETERANS ADMINISTRATION

Little has been required of your officers in carrying forth the V. A. program for the year just passed. The new fee schedule was received and accepted almost as presented by our very efficient Committee on Medical Care of Veterans. Adjustments will be recommended in the program as conditions indicate.

CANCER CONTROL

Much work has been done this year by our Cancer Committee. It has worked diligently in cooperation with the Ohio Division of the American Cancer Society and the Ohio Department of Health. These three have coordinated their work to bring about a uniform cancer control program for Ohio.

A Division of Cancer in the Ohio Department of Health has been established, headed by a full-time medical director. An advisory committee on cancer has been appointed by the State Director of Health. This committee consists of the members of the Cancer Committee of the Ohio State Medical Association. Every county society should have a Cancer Committee. A universal state plan is not at this moment an actuality, but is in the offing. Exhibits on cancer were placed at the A.M.A. meeting in Cleveland in January, and we are proud to have at this convention a similar exhibit which portrays the various activities of the three groups and the high spots of the uniform cancer control program being carried on in the State, or contemplated.

There is great need for educational activities among members of the medical profession with respect to the cancer control program. Lay groups which have raised funds for cancer control are anxious to spend their funds, and it is im-

perative for the medical profession to guide them in such matters.

Officials of the Ohio Division of the American Cancer Society are exceedingly anxious to have the advice and guidance of the medical profession in meeting questions which have arisen in connection with the activities of local cancer groups.

EXTENSION OF ACTIVITIES

A Committee on Extension of Activities was appointed by my predecessor. Much has been accomplished as a result of its work. The executive offices were remodeled and to a great extent, re-equipped. An assistant managing editor of *The Journal* has been appointed.

The Public Relations Department has been enlarged and now has its own director, assistant director, and personnel.

The *OSMagram* was born, and is issued once a month midway between issues of *The Journal*. Copies are sent not only to members of O.S.M.A., but to officers and committee members of the Woman's Auxiliary.

The Speakers Bureau was reorganized. It lists the names of over 400 speakers and their subjects. It should be a boon to the program chairman of any county society.

The "Guidepost," sent out with each member's membership card, was certainly a masterpiece. It offered information on the services of our Columbus Office and much information that any member could use at sometime or other.

We believe that all county societies should have a Speakers Bureau to provide speakers for lay groups. These speakers should be carefully selected. The Headquarters Office in Columbus supplies many speakers for lay groups on request.

Your Association is proceeding with arrangements to provide and show exhibits before lay groups or at county fairs, under the sponsorship of the local medical society.

More effort is being made to bring younger men, and especially general practitioners, into the activities of the local societies and the State Association. Some general practitioners claim they are too busy, but no man is too busy to do the thing he really wants to do.

This brings me to the part of my story that we shall refer to as recommendations.

RECOMMENDATIONS

1. County societies should put the younger men within their ranks to work. Give them a job to do and reward them in accordance with the performance. Let the offices of our component societies be filled with men who are putting out the time and effort and not to those who are said to be "in line" for office because of seniority or some other important reason.

2. Resolutions for consideration by the House of Delegates should be presented 30 days prior

to the Annual Meeting, if at all possible, so the Executive Secretary can submit as much material as possible to delegates in advance of the first session of the House of Delegates. This would not only expedite its transactions, but would permit a delegate to come to the meeting well-informed on questions to be discussed.

3. Each member should have a certificate of membership for framing or hanging in his office.

4. The city and the date for the annual convention of our Association should be selected by the House of Delegates at least two years in advance.

5. Certificates of distinction and gold pins should be issued to all members of our Association who have practiced for 50 years or more.

CONCLUSION

And so, in conclusion, I bow with deepest respect before you, the members of this Association, who have, by your choice, made this year one of the happiest of my life. The thoughts, suggestions, and recommendations of this address have come to me only through long and intimate working contact with many sound and well-balanced medical minds throughout this and neighboring states, worth-while men, good physicians, wise leaders, all joined in a common purpose. That our great Ohio State Medical Association shall continue to grow in honor, influence, and prestige, as the years of our second century roll on, is my fondest hope.

Nine Hospital Projects Set for Participation in Federal Aid

Seven projects for hospital construction under the Federal Hill-Burton Law had been forwarded to the Surgeon General of the U. S. Public Health Service by the Ohio Department of Health at the time this article was written, and two others were being prepared for forwarding, according to A. J. Borowski, Dr. P. H., chief of the Hospital Facilities Office.

The hospital projects forwarded for approval are those at Washington Court House, Ashtabula, Xenia, Nelsonville, Defiance, Wilmington, and the Richland County's new tuberculosis hospital at Mansfield. Those being prepared for forwarding are projects at Urbana and Bellefontaine.

The nine projects will consume \$2,430,352.99 of the Federal Government's first year's appropriation. Possibly one other small project will be approved for the first year, leaving only a small required reserve out of the \$2,692,125 made available for the first year. A summary of the plan appeared in the March issue of *The Journal*.

Official Proceedings of House of Delegates, Ohio State Medical Association, at 1948 Annual Meeting

MINUTES OF FIRST SESSION

THE first session of the House of Delegates, held in conjunction with the 1948 Annual Meeting of the Ohio State Medical Association, convened in the Hall of Mirrors, Netherland Plaza, Cincinnati, Ohio, on Tuesday evening, March 30, 1948, following a complimentary dinner for all delegates.

The meeting was called to order by Dr. D. W. Heusinkveld, Cincinnati, president-elect of the Cincinnati Academy of Medicine, substituting for Dr. M. A. Blankenhorn, president of the Cincinnati Academy of Medicine and general chairman of the local arrangements, who was unable to be present. Dr. Heusinkveld welcomed the delegates and other members of the Association to Cincinnati and then introduced the President, Dr. R. L. Rutledge, Alliance, who delivered his presidential address. (See page 497 in this issue for Dr. Rutledge's address.)

The roll of delegates was called, 121 being present.

On motion by Dr. J. Craig Bowman, Upper Sandusky, seconded by Dr. Paul A. Davis, Akron, and carried, the minutes of the sessions of the House of Delegates held in May, 1947, were approved.

REFERENCE COMMITTEES APPOINTED

The following reference committees were appointed by Dr. Rutledge to consider business coming before the House of Delegates and for reports back to the House:

Resolutions—G. A. Woodhouse, Pleasant Hill, chairman; William J. Graf, Cincinnati; Frank M. Wiseley, Findlay; Foster Myers, Toledo; R. J. Whitacre, Cleveland; William M. Skipp, Youngstown; S. L. Burkhardt, Steubenville; L. A. Hamilton, Athens; Francis Shane, Gallipolis; Charles W. Pavey, Columbus; and S. D. Nielsen, Elyria.

President's Address—A. R. Basinger, Canton, chairman; M. Paul Motto, Cleveland; D. W. Hogue, Springfield; H. M. Lowell, Hamilton; and F. M. Hartsook, Cardington.

Time and Place of Annual Meeting—R. E. Pinkerton, Akron, chairman; Ralph W. Holmes, Chillicothe; Farrell T. Gallagher, Lakewood; M. D. Prugh, Dayton; and Fred P. Berlin, Lima.

Credentials—D. J. Slosser, Defiance, chairman; Leo D. Covert, Bellaire; and Joseph Lindner, Cincinnati.

Tellers and Judges of Election—W. B. Recker, Leipsic, chairman; J. E. Gillette, Versailles; J. Martin Byers, Greenfield; Morris G. Carmody, Painesville; and V. A. Killoran, Sandusky.

In compliance with the Constitution and By-Laws, the President then asked for nominations

of representatives from the eleven Councilor Districts for the Committee on Nominations.

NOMINATING COMMITTEE ELECTED

The following delegates were nominated and duly elected to the Committee on Nominations:

First District—Emil R. Swepston, Cincinnati.

Second District—M. D. Prugh, Dayton.

Third District—Fred P. Berlin, Lima.

Fourth District—D. J. Slosser, Defiance.

Fifth District—C. G. LaRocco, Cleveland.

Sixth District—William M. Skipp, Youngstown.

Seventh District—C. F. Goll, Hopedale.

Eighth District—G. A. Gressle, Newark.

Ninth District—W. A. Quinn, Portsmouth.

Tenth District—R. W. Holmes, Chillicothe.

Eleventh District—Ross M. Knoble, Sandusky.

RESOLUTIONS INTRODUCED

The next order of business was the introduction of resolutions.

Resolutions were introduced by the following: Dr. Foster Myers, Toledo; Dr. H. M. Clodfelter, Columbus; Dr. R. Dean Dooley, Dayton; Dr. E. J. Wenaas, Youngstown; Dr. Emil R. Swepston, Cincinnati; Dr. L. A. Witzeman, Akron; Dr. E. P. McNamee, Cleveland; Dr. E. O. Swartz, Cincinnati; and Dr. Joseph D. Stires, Malvern. All were referred without debate to the Reference Committee on Resolutions.

(See Minutes of Second Session of House of Delegates for texts of resolutions and action on them by the House of Delegates.)

INVITATION FROM COLUMBUS

On behalf of the Columbus Academy of Medicine, the Columbus Chamber of Commerce, the Columbus Hotels and Convention Bureau, Dr. H. M. Clodfelter, Columbus, presented an invitation to the Association to hold its 1949 Annual Meeting at Columbus. The invitation was referred to the Reference Committee on Time and Place of Annual Meeting.

CHARTER RE-ISSUED

A request from the Wyandot County Medical Society for a re-issued charter, the original having been lost, was considered. The House was advised that The Council by appropriate action had authorized the re-issuance of this charter and that the action of The Council had to be confirmed by the House of Delegates. On motion by Dr. Paul A. Davis, seconded by Dr. H. P. Worstell, Columbus, and carried, the President and the Executive Secretary were

authorized to sign and re-issue officially a charter to the Wyandot County Medical Society.

There being no further business, the House of Delegates recessed until Thursday noon, April 1.

MINUTES OF SECOND SESSION

The second session of the House of Delegates was called to order by President Rutledge at 1:00 p. m., April 1, 1948, in the Hall of Mirrors, Netherland Plaza, Cincinnati.

The roll call showed 121 delegates present.

Under the item of unfinished business, President Rutledge announced that a special committee, which he had appointed to review the scientific exhibits and recommend awards, had reported as follows:

SCIENTIFIC EXHIBIT AWARDS

First Award—"Papanicolaou Technique," Dr. Douglas P. Graf, Department of Surgery, Cincinnati General Hospital, Cincinnati.

Second Award—"Cerebral Angiography," Dr. Frank H. Mayfield, Dr. Edgar S. Lotspeich, Jr., and Dr. James R. Simpson, Cincinnati.

Third Award—"Punch Biopsy of the Liver," Gastric Laboratory, Department of Internal Medicine and Department of Pathology, Cincinnati General Hospital, Cincinnati.

Dr. Rutledge stated that the committee did not consider for the first, second, and third awards the exhibits presented by the governmental agencies, but that the committee recommended they be given honorable mention and a vote of thanks for having participated.

Honorable mention also was given to the following: Dr. G. M. Guest, Dr. W. Brodsky, and Mrs. J. Garvin, Children's Hospital, Cincinnati, for their exhibition "Juvenile Diabetes: Management with Unrestricted Dietary Regime"; and Dr. Joseph L. Morton, Dr. G. A. Erhard, and Dr. T. E. Fox, Ohio State University, Columbus, for their exhibit on "Radiographic Aids in Hematology."

On motion by Dr. C. T. Atkinson, Middletown, seconded by Dr. R. S. Binkley, Dayton, and carried, the recommendations of the special committee on scientific awards were approved, and a vote of thanks given to all who participated in the Scientific Exhibit and the Committee on Scientific Exhibit, of which Dr. William F. Ashe, Cincinnati, was chairman.

TRIBUTE TO DR. D. C. HOUSER

Dr. William M. Skipp, Youngstown, obtained recognition from the chair and moved that the House of Delegates pay tribute by a rising vote to Dr. D. C. Houser, Urbana, delegate from Champaign County, who has served continuously for 46 years in the House of Delegates and who

was celebrating his eighty-first birthday on April 1. The motion was seconded by many delegates and carried by a rising vote, accompanied by applause. Dr. Houser was presented to the House of Delegates and expressed appreciation for the tribute paid to him.

REPORT ON PRESIDENT'S ADDRESS

The next order of business was the report of the Reference Committee on President's Address. Dr. A. R. Basinger, Canton, presented the following report on behalf of the committee which, on motion by Dr. Basinger, seconded by Dr. W. A. Quinn, Portsmouth, and carried, was approved:

"The Committee on President's Address, after due deliberation on the accomplishments and objectives of the Ohio State Medical Association expressed in the address of Dr. Rutledge, wishes to submit the following report:

"The grateful acknowledgment of Dr. Rutledge that his leadership and accomplishments have been initiated and sparked by the unity of action of the officers and the entire membership of the Association is a motive to be fostered and cherished in succeeding years.

"It will be noted from the President's Address that the 25-point program adopted in 1945 is being carried forward gradually but decisively toward completion. Continuity of purposes and plans has been one of the valuable factors in the growth and development of the Ohio State Medical Association.

"You will notice in the address an early change of the pronoun 'I' to 'we,' as Dr. Rutledge nicely and sincerely recognizes the teamwork of The Council, executive staff, committees, and members.

WOMAN'S AUXILIARY

"Dr. Rutledge recognized (and it will be noted that this is one of the first items in his address) the powerful influence for good of the Woman's Auxiliary. Along this line, the President points out that our ladies have helped and will continue to help refill our reservoir of goodwill in the minds of the public, fighting as it were a rear-guard action while we are marshalling our forces against socialized medicine and socialism in general. The President asks that we all recognize the Woman's Auxiliary and aid in its promotion wherever possible. This we gladly endorse.

OHIO MEDICAL INDEMNITY

"Gratifying is the report by Dr. Rutledge on the growth and development of Ohio Medical Indemnity, the voluntary prepaid medical care plan, organized and sponsored by the Association.

"He reports that Ohio Medical Indemnity now has an enrollment of approximately 345,000 persons. It is pointed out that only two years after beginning operation, Ohio Medical Indemnity is able to redeem the \$100,000 of preferred stock and to enlarge its benefits to subscribers. This plan is our answer to compulsory governmental health insurance. It is now available in 82 of our 88 counties. Certainly this project, one of the '25 points,' should be 'kept alive' and we certainly hope that it will add many additional thousands of subscribers during the coming year. It must be that the public has caught some of the contagious enthusiasm with which our doctors have accepted this program. There is evidence here that the best defense against Federal

control and a New Deal type of compulsory health insurance is a good offense.

LOOK AT THE FUTURE

"Dr. Rutledge takes a studious look at the future and suggests continued opposition to political control of medicine, more we infer, by removing the need for governmental interference. He suggests that the medical profession take it upon itself to heal some of the ulcers which we know to be present in modern society.

"We believe as he does that hospitals must be made more accessible to rural people. At this point your committee feels that as we promote bigger, better, and more hospitals, we should recognize an ever-present danger, namely, the danger emanating from the fact that some hospital administrators are endeavoring to control professional activities in their institutions, which function rightfully belongs to the members of the medical profession working in the hospital.

HOSPITAL PROGRAM

"Likewise, may we point out that the Federal grant-in-aid for hospital construction must be used judiciously and certainly not in any way which would bring about the Federalization of either hospitals or the medical profession. We believe that under the setup of the Ohio Hospital Plan, the Hospital Advisory Council, working as a consulting group, will be in a position to guide on matters of policy, and we urge it to safeguard carefully the interests of the medical profession as well as the interests of the public. We see here a fine opportunity to help in the healing of another of the difficulties confronting our people.

NEED FOR GENERAL PRACTITIONERS

"Dr. Rutledge points out that the building of new hospitals and health centers will greatly increase the need for more physicians and nurses, especially in the rural areas where there is, at the present time, a serious shortage. This problem is being investigated by the Committee on Rural Health and the Committee on Education. Questionnaires were sent to medical students, interns, and residents and the data compiled are now being studied and analyzed. This matter is discussed in detail in the President's talk.

RURAL PROBLEMS

"In Dr. Rutledge's address, we are advised of the need for urging more rural students to study medicine, and of the need for sound plans to aid them in obtaining their medical training. The assistance of the deans of our three medical schools has been solicited, especially in the development of more general practitioners. Dr. Rutledge made a constructive criticism of the present curriculum of many of our medical schools, in that they tend to discourage students from entering the general practice of medicine. He suggests that more time be devoted to teaching the diagnosis and treatment of the more common diseases and to routine office practice. Also, he recommends that the schools have as a requirement an externship with some general practitioner. Moreover, he suggests the possibility of scholarships for boys from rural high schools desiring to enter the practice of medicine.

NURSING SITUATION

"In order to improve the nursing situation, Dr. Rutledge suggests that we must give encouragement to our small nurses' training schools.

The larger nursing schools have tended to center on education for those who wish to become supervisors, hospital and school administrators, industrial nurses, and public health nurses. As he points out, the public, the medical profession, and the hospitals are demanding adequate nursing care. There is a need for more bedside nurses. The nursing army cannot be made up entirely of 'five-star generals.' What we need are more buck privates. At the same time, nursing must be made more attractive. Considerable thought should be given to the question of adjusting the salary schedules of nurses so that they will compare more favorably with the remuneration received by the girl working in the office or in the factory.

CANCER CONTROL PROGRAM

"The Cancer Control Program, another delicate problem in Ohio, is discussed in some detail by the President. This project can be, and is in some areas, a source of controversy. This is not surprising as it is a new adventure and, until the flaws are spotted and remedied, it probably will not work as smoothly as all would desire. Your Committee feels that we should give a vote of confidence to the Cancer Committee, which has worked diligently on this matter.

EXTENSION OF ACTIVITIES

"The President reports on the progress of the Committee on Extension of Activities in enlarging the Public Relations Department; reorganization of the Speakers Bureau; providing exhibits for the public, through which valuable information on the prevention, control, and treatment of disease can be disseminated; the issuance of the *OSMAgram* to all members each month; the preparation and distribution of the "Guidepost" pamphlet, providing information about the services offered by the Headquarters Office and various committees; improvements in *The Journal*, one of the best in its field; and other new and revitalized activities undertaken during the past year. These are evidences of the growth and of the united effort to enlarge the functions and services of our organization.

RECOMMENDATIONS

"In his concluding remarks, Dr. Rutledge offers the following specific recommendations:

"1. Younger men should be put to work in the county society offices and activities.

"2. Resolutions for consideration by the House of Delegates should be published at least 30 days prior to the Annual Meeting, if at all possible, so that Delegates may be given more time to review and study the content of the resolutions.

"3. A certificate of membership should be issued to each member of the Association for display in his office.

"4. The time and place for the Annual Meeting of the Association should be selected three years in advance, this authority to be delegated to The Council.

"5. Certificates of distinction and gold pins should be issued to all members of the Association who have been engaged in practice for at least 50 years.

"Your Committee recognizes the sagacity of these recommendations and is in accord with them.

"We feel that the address of Dr. Rutledge is

a most interesting review of the year's accomplishments and a stimulating guidepost for future officers of the Association."

ACTION ON RESOLUTIONS

President Rutledge then called for the report of the Reference Committee on Resolutions. This report, reading as follows, was presented by Dr. G. A. Woodhouse, Pleasant Hill, chairman of the committee, on behalf of the committee.

RESOLUTION A

"Resolution A, reading as follows, was introduced by Dr. Foster Myers, Toledo:

"Whereas, the adoption of a so-called 'Inter-American Charter of Social Guarantees' will be proposed at the Ninth International Conference of American States now being held in Bogota, Colombia, and

"Whereas, one article of this proposed charter would, in effect, place such conference on record as favoring a system of compulsory sickness, maternity, and disability insurance in all of the American states, including the United States, and

"Whereas, it is understood that this action is being sponsored by the International Labor Organization, which has been promoting world socialization, with the blessing and active assistance of high officials of the Social Security Agency and other agencies of the United States Government, therefore

"Be It Resolved, that the House of Delegates of the Ohio State Medical Association herewith voices vigorous objection to having the United States subscribe to the article referred to above because neither the people nor the Congress of the United States has endorsed compulsory sickness insurance with its many attending evils, and further

"Be It Resolved, that the President of the Ohio State Medical Association shall be instructed to advise General George C. Marshall, Secretary of State and Chairman of the United States delegation to the Bogota Conference of this action by this House of Delegates, and further

"Be It Resolved, that a copy of this resolution shall be sent to each Ohio member of the United States Congress, the authority of which is being usurped by certain Federal employees who are playing a prominent part in the world socialization movement.

"Your committee is heartily in favor of the sentiments expressed in this resolution. It suggests a number of minor revisions in the resolution and recommends the adoption of the resolution, as amended, reading as follows:

AMENDED RESOLUTION A

"Whereas, the adoption of a so-called 'Inter-American Charter of Social Guarantees' will be proposed at the Ninth International Conference of American States now being held in Bogota, Colombia, and

"Whereas, one article of this proposed charter would, in effect, place such conference on record as favoring a system of compulsory sickness, maternity, and disability insurance in all of the American states, including the United States, and

"Whereas, it is understood that this action is being sponsored by the International Labor Organization, which has been promoting world socialization, with the approval and active assistance of high officials of the Social Security Agency and other agencies of the United States Government, and

"Whereas, the authority of the Congress is being usurped by certain Federal employees who are playing a prominent part in the world socialization movement, therefore

"Be It Resolved, that the House of Delegates of the Ohio State Medical Association herewith voices vigorous objection to having the United States subscribe to the article referred to above because neither the people nor the Congress of the United States has endorsed compulsory sickness insurance with its many attending evils, and further

"Be It Resolved, that the President of the Ohio State Medical Association shall be instructed to advise General George C. Marshall, Secretary of State and Chairman of the United States delegation to the Bogota Conference, of this action by this House of Delegates, and further

"Be It Resolved, that a copy of this resolution shall be sent to each Ohio member of the United States Congress."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Amended Resolution A be adopted, was approved.

RESOLUTION B

"Resolution B was introduced by Dr. H. M. Clodfelter, Columbus. It read as follows:

"Whereas, Senate Bill 1290, now pending in the United States Senate would provide Federal grants-in-aid to the different states for the purpose of establishing programs for the prevention, diagnosis, and treatment of physical and mental defects and conditions of school children, and

"Whereas, this measure would provide health services, including curative services, at government expense to more than 30,000,000 school children without regard to the ability of the family to purchase the needed services, and

"Whereas, it contains serious administrative defects and uncertainties, as pointed out to a recent Senate sub-committee by Dr. James R. Miller, member of the Board of Trustees of the American Medical Association, and

"Whereas, there is no evidence to show that the individual states are unable to finance a school health program without Federal financial assistance, therefore

"Be It Resolved, that the Ohio State Medical Association, although it is deeply interested in the health of school children and in seeing that sound school health programs are maintained in all communities, cannot endorse S. 1290 which it considers unsound in principle.

"For reasons well explained in the resolution, your committee favors its adoption and recommends that the House of Delegates approves and adopts Resolution B."

On motion duly made, seconded, and unanimously carried, the recommendation of the com-

mittee, namely, that Resolution B be adopted, was approved.

RESOLUTION C

"Resolution C, reading as follows, was introduced by Dr. R. Dean Dooley of Dayton:

"Whereas, the Montgomery County Medical Society believes that the title 'Dr.' is being used indiscriminately; and

"Whereas, this indiscriminate use is confusing to persons in search of medical care to the extent of their being unable to determine the type of practitioner by his listing; and

"Whereas, this condition is becoming more serious due to the increase in the number of irregular practitioners; therefore,

"Be It Resolved, that the Ohio State Medical Association take the proper measures to promote the passage of state legislation prohibiting any person for any purpose in any manner from using the title 'Dr.' before his or her name, except where there is shown after the name, the letters indicating the type of a degree for which a doctorate is claimed.

"Your committee agrees with the fundamental purposes set forth in this resolution; however, it is of the opinion that certain portions of it need clarification. Therefore, it offers a substitute resolution, reading as follows, and recommends the adoption of the substitute resolution:

SUBSTITUTE RESOLUTION C

"Whereas, the Montgomery County Medical Society believes that the title 'Dr.' is being used indiscriminately; and

"Whereas, this indiscriminate use is confusing to persons in search of medical care to the extent of their being unable to determine the type of practitioner by his listing; and

"Whereas, this condition is becoming more serious due to the increase in the number of irregular practitioners; therefore,

"Be It Resolved, that The Council of the Ohio State Medical Association take the proper steps to promote the passage of a law by the Ohio General Assembly which would prohibit any person engaged in the practice of medicine or any of its branches from using the title 'Doctor' or 'Dr.' before his or her name, except where there is shown after the name the abbreviation indicating the type of degree for which a doctorate is claimed."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Substitute Resolution C be adopted, was approved.

RESOLUTION D

"Resolution D, also introduced by Dr. Dooley, read as follows:

"Whereas, the Montgomery County Medical Society considers the shortage of interns a problem of major importance to the physicians and hospitals of Ohio; and

"Whereas, many private hospitals in Ohio are unable to obtain interns; and

"Whereas, there are, on a national basis in approximate figures, 8,700 approved internships with only 5,300 medical school graduates eligible for these openings; and

"Whereas, this shortage of 3,400 will be further increased by the constant expansion of government sponsored hospitals which pay intern salaries in excess of those which non-government hospitals are able to pay, and the additional demand for interns by teaching hospitals, plus residencies in the various specialties; therefore,

"Be It Resolved, that the Ohio State Medical Association appoint a committee to make a thorough study of the current intern shortage in non-government hospitals and report its findings with recommendations for solving the problem to The Council of the Ohio State Medical Association for appropriate action.

"Your committee believes this is a good resolution and recommends its adoption with certain amendments in the final paragraph. As amended, the final paragraph would read as follows:

"Be It Resolved, that the Committee on Education of the Ohio State Medical Association be instructed to make a thorough study of the current shortage of interns and cooperate with The Council on Medical Education and Hospitals of the American Medical Association on this question, and further

"Be It Resolved, that the committee report its findings with recommendations for solving the problem to The Council of the Ohio State Medical Association for appropriate action."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Resolution D, as revised, be adopted, was approved.

RESOLUTION E

"Resolution E was introduced by Dr. E. J. Wenaas of Youngstown and read as follows:

"Whereas, the members of the Mahoning County Medical Society are fully conscious of the most effective and continuously progressive program of the N.P.C. for the extension of medical service in its dissemination of factual information on values, methods, and accomplishments of American medicine, and

"Whereas, the public, as a result has not only been generally enlightened on contributions, achievements, and true aims of the medical profession of the U. S., but has also been warned of the dangers to the public health implied in the subtle campaign which would discredit the doctor, therefore

"Be It Resolved, that the members of the Mahoning County Medical Society give their approval to the activities of the N.P.C. and recommend that all members of the profession of this county give adequate financial and moral support to the N.P.C.

"Be It Further Resolved, that the delegates of the Mahoning County Medical Society meeting in annual session in Cincinnati, Ohio, March 30-31, April 1, be instructed to present this resolution for the approval of the House of Delegates of the Ohio State Medical Association.

"Your committee studied this resolution in considerable detail and reviewed actions of The Council and the House of Delegates on similar resolutions during the past six or seven years. The last action taken by the House of Delegates on the question covered by Resolution E occurred

in 1944 when the House of Delegates adopted the following statement of policy:

"That affiliation with the National Physicians Committee is a matter to be decided individually by members of the medical profession."

"Your committee believes that the policy adopted in 1944 was sound and it believes that there is no need for a change in that policy at this time.

"Therefore, your committee recommends that the House of Delegates not adopt Resolution E."

On motion, duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Resolution E not be adopted, was approved.

RESOLUTION F

"Resolution F, reading as follows, was introduced by Dr. Emil R. Swepston of Cincinnati:

"Whereas, members of the House of Delegates are elected to represent the will of the component county societies;

"Be It Resolved, that all resolutions for the consideration of that body be presented sufficiently in advance of the annual assembly to permit publication in *The Ohio State Medical Journal* next preceding, except that matters presented by The Council of the Ohio State Medical Association may be introduced by the consent of two thirds of the House of Delegates.

"The purposes and objectives of this resolution meet with the approval of your committee, since it believes that as many members of the Association as possible, especially members of the House of Delegates, should be familiar with the business to be considered by the House of Delegates prior to its annual sessions.

"However, there are certain practical problems which must be taken into consideration in efforts to publicize to the membership resolutions prior to their introduction into the House of Delegates. For that reason, your committee has taken the liberty of drafting a substitute resolution, which it recommends to the House of Delegates for adoption. The substitute resolution reads as follows:

SUBSTITUTE RESOLUTION F

"Whereas, members of the Ohio State Medical Association, especially members of the House of Delegates who are elected to represent component county medical societies in the business transactions of the Association, should be advised if at all possible of matters to be considered by the House of Delegates at the Annual Meeting of the Association; therefore

"Be It Resolved, that whenever possible all resolutions for consideration by the House of Delegates shall be submitted to the Columbus Headquarters Office sufficiently in advance of the Annual Meeting to permit publication of such resolutions in the issue of *The Ohio State Medical Journal* appearing at least 30 days prior to the Annual Meeting."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Substitute Resolution F be adopted, was approved.

RESOLUTION G

"Resolution G was introduced by Dr. L. A. Witzeman of Akron and read as follows:

"Whereas, much displeasure, dissatisfaction, and discrimination has arisen in Ohio hospitals, between the medical association and the hospitals, and

"Whereas, some hospitals have disregarded the resolutions of the American Medical Association and the House of Delegates of the Ohio State Medical Association, in regard to staff appointments, and

"Whereas, this is not in the best interest of the public and the medical profession, and

"Whereas, the resulting disagreement and discrimination in the medical profession tends to foster the Federalization of medicine, therefore

"Be It Resolved, that the House of Delegates of the Ohio State Medical Association go on record as being strongly opposed to such actions, and furthermore

"Be It Resolved, that the Ohio State Medical Association advise all hospitals registered under the laws of Ohio, that the professional operation of the hospitals be delegated to the physicians of those hospitals, and that the administrative staffs confine their activities strictly to the business administration of the hospital, and

"Be It Further Resolved, that the staff of any hospital shall be chosen on a basis of merits, aptitude, training, experience, skill, and professional standing of the physician who applies for such staff appointment or privileges, and not on Board certification, or on membership in any specialty society.

"There was considerable discussion of the question raised by this resolution, inasmuch as the question has become one of general state-wide importance. Your committee believes that an immediate solution to this question is imperative. Therefore, with minor amendments, primarily for the purpose of clarification, your committee recommends the adoption of Resolution G, which, as amended, reads as follows:

AMENDED RESOLUTION G

"Whereas, much displeasure, dissatisfaction, and discrimination has arisen in Ohio hospitals, between the medical association and the hospitals, and

"Whereas, some hospitals have disregarded the resolutions of the American Medical Association and the House of Delegates of the Ohio State Medical Association, in regard to staff appointments, and

"Whereas, this is not in the best interest of the public and the medical profession, therefore,

"Be It Resolved, that the House of Delegates of the Ohio State Medical Association go on record as being strongly opposed to such actions, and furthermore,

"Be It Resolved, that the Ohio State Medical

Association advise all hospitals registered under the laws of Ohio, that the professional operation of the hospitals be delegated to the physicians of those hospitals, and that the administrative staffs confine their activities strictly to the business administration of the hospital, and

"Be It Further Resolved, that the staff of any hospital shall be chosen on a basis of merits, aptitude, training, experience, skill, and professional standing of the physician who applies for such staff appointment or privileges, and not on Board certification, or on membership in any specialty society."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Amended Resolution G be adopted, was approved.

RESOLUTION H

"Resolution H, which was introduced by Dr. E. P. McNamee, Cleveland, read as follows:

"Whereas, it is essential that the people of all areas of Ohio should have the benefits accruing from services offered by an efficiently operated and well-financed full-time local health department, therefore

"Be It Resolved, that the Ohio State Medical Association recommends to the Director of the Ohio Department of Health that he appoint a committee to study the present system of local public health services in Ohio and to formulate recommendations as to how it can be improved, and further,

"Be It Resolved, that the Ohio State Medical Association offer its active support and guidance to such committee.

"Your committee believes that the study proposed in the resolution would be a constructive project. For that reason, it recommends the adoption of the resolution."

On motion, duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Resolution H be adopted, was approved.

RESOLUTION I

"Resolution I, reading as follows, was introduced by Dr. E. O. Swartz of Cincinnati:

"Whereas, Ohio Medical Indemnity, Inc., the 'Doctors' Plan,' sponsored by the Ohio State Medical Association, now has a total enrollment of approximately 345,000 subscribers, making it the sixth largest medical society-sponsored, voluntary prepayment medical care plan in the country, and

"Whereas, Ohio Medical Indemnity during 1947 showed an enrollment increase of 310 per cent, ranking fifth among voluntary medical care plans in net enrollment increase last year, and

"Whereas, Ohio Medical Indemnity has been able to increase and extend its coverage and benefits because of the sound and efficient management policies adopted and followed by its board of directors, executive committee, officers and executive staff, ably assisted by the officials and executives of the Blue Cross Plans in Ohio which are providing essential administrative services for Ohio Medical Indemnity, therefore,

"Be It Resolved, that the House of Delegates of the Ohio State Medical Association commends all who have had a part in making Ohio Medical Indemnity an outstanding success; expresses sincere appreciation to the Ohio Blue Cross Plans which have cooperated with the officials of Ohio Medical Indemnity; and urges all members of the Ohio State Medical Association to continue to give this project their loyal support and cooperation, as in the past, to the end that Ohio Medical Indemnity may be able to provide greater benefits to an increasing number of Ohio citizens.

"The committee is in full accord with the content of the resolution and wishes to add its commendations to those who have played a vital part in making Ohio Medical Indemnity an outstanding success. It recommends the adoption of the resolution."

On motion duly made, seconded, and unanimously carried, the recommendation of the committee, namely, that Resolution I be adopted, was approved.

RESOLUTION J

"Resolution J, which was introduced by Dr. Joseph D. Stires of Malvern, read as follows:

"Whereas, many are the trials and tribulations of the medical profession today which can be attributed directly or indirectly to the overemphasis on specialization, and

"Whereas, this overemphasis has caused the profession to be top-heavy with specialists; tends to encourage over-treatment and unnecessary services; and reduces the number of physicians in the general practice of medicine, especially in rural areas, and

"Whereas, the physician entering a specialty directly from hospital training is in many instances not well versed in anything but his specialty and, although highly trained scientifically, often lacks training and experience in the art of medicine which only general practice can give him, therefore

"Be It Resolved, that this House of Delegates recommends that at least five years in the general practice of medicine after internship shall be made a requirement of all specialty boards for admission to examination and certification, provided, however, that time served in the armed forces shall be credited toward such five-year requirement, and further,

"Be It Resolved, that this recommendation shall be transmitted to the American Medical Association and to each recognized specialty board.

"Your committee favors the aims and objectives specified in the resolution. Therefore, with certain amendments, offered for purposes of clarification, the committee recommends the adoption of amended Resolution J, reading as follows:

AMENDED RESOLUTION J

"Whereas, many are the trials and tribulations of the medical profession today which can be attributed directly or indirectly to the overemphasis on specialization, and

"Whereas, this overemphasis has caused the profession to be top-heavy with specialists and reduces the number of physicians in the general

practice of medicine, especially in rural areas, and

"Whereas, the physician entering a specialty directly from hospital training is in many instances not well versed in anything but his specialty and, although highly trained scientifically, often lacks training and experience in the art of medicine which only general practice can give him, therefore

"Be It Resolved, that this House of Delegates recommends that at least five years in the general practice of medicine prior to specialty training shall be made a requirement of all specialty boards for admission to examination and certification, provided however, that time served in the armed forces shall be credited toward such five-year requirement, and further,

"Be It Resolved, that this recommendation shall be transmitted to the American Medical Association and to each recognized specialty board."

Dr. Woodhouse moved that the action of the committee, recommending the adoption of Resolution J, as amended, be approved. The motion was seconded by Dr. A. R. Basinger, Canton.

There was considerable discussion of the resolution and opposition to its adoption voiced by many delegates based on the contention that the House of Delegates had insufficient and inadequate information on this question.

Dr. L. D. Covert, Bellaire, moved that the recommendation of the Reference Committee, that Resolution J, as amended, be approved, be laid on the table. The motion was seconded by Dr. C. L. Hudson, Cleveland. By a rising vote of 64 to 42, the motion to lay on the table was approved.

On motion duly made, seconded, and unanimously carried, the report of the Reference Committee on Resolutions as a whole, and as amended by action of the House of Delegates, was approved.

COLUMBUS SELECTED FOR 1949

Dr. R. E. Pinkerton, Akron, chairman of the Reference Committee on Time and Place of the 1949 Annual Meeting, reported that his committee recommended acceptance of the invitation from Columbus to hold the 1949 Annual Meeting in that city the week of April 17.

On motion duly made, seconded, and unanimously carried, the recommendation of the reference committee was approved.

DR. LINCKE NAMED PRESIDENT-ELECT

President Rutledge announced that the next order of business would be the nomination and election of a President-Elect and he called for nominations from the floor.

Dr. L. E. Anderson, Greentown, placed in nomination the name of Dr. Carl A. Lincke, Carrollton, retiring Councilor of the Seventh District.

Dr. W. A. Quinn, Portsmouth, placed in nomination the name of Dr. Gilbert R. Micklethwaite, Portsmouth, retiring Councilor of the Ninth District.

There being no further nominations, on motion duly made, seconded, and unanimously carried, the nominations were closed and the House of Delegates balloted for Dr. Lincke and Dr. Micklethwaite for the office of President-Elect.

Dr. W. B. Recker, Leipsic, chairman of the Committee on Tellers and Judges of Election, advised the President that the House of Delegates had cast 74 votes for Dr. Lincke and 35 votes for Dr. Micklethwaite, whereupon President Rutledge announced the election of Dr. Lincke as President-Elect.

At the request of the President, Dr. Anderson escorted Dr. Lincke to the platform for introduction to the House of Delegates.

ELECTION OF COUNCILORS

Dr. Rutledge then called for a report of the Committee on Nominations, which was presented on behalf of the committee by Dr. Emil R. Swepston, Cincinnati.

FIRST DISTRICT

As Councilor for the First District, the committee nominated Dr. E. O. Swartz, Cincinnati, to succeed himself for a term of two years. There being no further nominations, on motion duly made, seconded, and unanimously carried, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Swartz. This was done and Dr. Swartz was declared officially elected to The Council for the years 1948 and 1949.

THIRD DISTRICT

As Councilor for the Third District, the committee nominated Dr. J. Craig Bowman, Upper Sandusky, to succeed himself for a term of two years. There being no further nominations, on motion duly made, seconded, and unanimously carried, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Bowman. This was done and Dr. Bowman was declared officially elected to The Council for the years 1948 and 1949.

FIFTH DISTRICT

As Councilor for the Fifth District, the committee nominated Dr. Fred W. Dixon, Cleveland, to succeed himself for a term of two years. There being no further nominations, on motion duly made, seconded, and unanimously carried, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Dixon. This was done and Dr. Dixon was declared officially elected to The Council for the years 1948 and 1949.

SEVENTH DISTRICT

As Councilor for the Seventh District, the committee nominated Dr. R. J. Foster, New Philadelphia, to succeed Dr. Carl A. Lincke, Carroll-

ton, retiring Councilor of that district who had been elected President-Elect. There being no further nominations, on **motion** duly made, seconded, and unanimously **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Foster. This was done and Dr. Foster was declared officially elected to The Council for the years 1948 and 1949.

EIGHTH DISTRICT

As Councilor for the Eighth District, to serve an unexpired term of one year, namely 1948, the committee placed in nomination the name of Dr. C. P. Swett, Lancaster. Dr. Swett had been elected by The Council to succeed Dr. Arthur J. Tronstein, Newark, who had resigned in December, 1947, and to serve until this session of the House of Delegates. There being no further nominations, on **motion** duly made, seconded, and unanimously **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Swett. This was done and Dr. Swett was declared officially elected to The Council for the year 1948.

NINTH DISTRICT

As Councilor for the Ninth District, the committee nominated Dr. J. P. McAfee, Portsmouth, to succeed Dr. Gilbert R. Micklethwaite, Portsmouth, retiring Councilor of that district. There being no further nominations, on **motion** duly made, seconded, and unanimously **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. McAfee. This was done and Dr. McAfee was declared officially elected to The Council for the years 1948 and 1949.

ELEVENTH DISTRICT

As Councilor for the Eleventh District, the committee nominated Dr. John S. Hattery, Mansfield, to succeed Dr. Ross M. Knoble, Sandusky, retiring Councilor of that district. There being no further nominations, on **motion** duly made, seconded, and unanimously **carried**, the nominations were closed and the Secretary instructed to cast the unanimous ballot of the House of Delegates for Dr. Hattery. This was done and Dr. Hattery was declared officially elected to The Council for the years 1948 and 1949.

A.M.A. DELEGATES ELECTED

The committee then presented nominations for the offices of delegate and alternate to the American Medical Association to be filled at this year's meeting.

The names of Dr. E. P. McNamee, Cleveland, as delegate, and Dr. H. B. Wright, Cleveland, as his alternate, to serve for a term of two years, 1948 and 1949, were placed in nomination. There being no further nominations, on **motion** duly

made, seconded, and unanimously **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. McNamee and Dr. Wright. This was done and they were declared duly elected delegate and alternate to the American Medical Association for the years 1948 and 1949.

The names of Dr. Carl A. Lincke, Carrollton, as delegate, and Dr. H. M. Platter, Columbus, as his alternate, to serve for a term of two years, 1948 and 1949, were placed in nomination. There being no further nominations, on **motion** duly made, seconded, and unanimously **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Lincke and Dr. Platter. This was done and they were declared duly elected delegate and alternate to the American Medical Association for the years 1948 and 1949.

The names of Dr. G. A. Woodhouse, Pleasant Hill, as delegate, and Dr. R. S. Binkley, Dayton, as his alternate, to serve for a term of two years, 1948 and 1949, were placed in nomination. There being no further nominations, on **motion** duly made, seconded, and unanimously **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Woodhouse and Dr. Binkley. This was done and they were declared duly elected delegate and alternate to the American Medical Association for the years 1948 and 1949.

The names of Dr. William M. Skipp, Youngstown, as delegate, and Dr. Russel G. Means, Columbus, as his alternate, to serve for a term of two years, 1948 and 1949, were placed in nomination.

Dr. Oliver E. Todd, Toledo, placed in nomination the name of Dr. C. E. Hufford, Toledo, as alternate to Dr. Skipp. Inasmuch as two nominations for the office of alternate had been made, President Rutledge ruled that there should be a division of the election for these particular offices and this met with the approval of the House of Delegates.

There being no further nominations for the office of delegate, on **motion** duly made, seconded, and unanimously **carried**, the nominations for the office of delegate were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Skipp. This was done and he was declared duly elected delegate to the A.M.A. for the years 1948 and 1949.

There being no further nominations for the office of alternate to Dr. Skipp, the nominations were closed, on **motion** duly made, seconded, and unanimously **carried**, and the House of Delegates balloted for Dr. Means and Dr. Hufford as alternate-delegate. Dr. W. B. Recker, Leipsic, chair-

man of the Committee on Tellers and Judges of Election, reported to the President that the House of Delegates had cast 55 votes for Dr. Hufford and 26 votes for Dr. Means, whereupon the President announced the election of Dr. Hufford as Dr. Skipp's alternate to the A.M.A. for the years 1948 and 1949.

The Nominating Committee then placed in nomination the name of Dr. Frank M. Wiseley, Findlay, as delegate to the American Medical Association for a term of one year, 1948, to fill the unexpired term of the late Dr. Barney J. Hein, Toledo; and the name of Dr. H. W. Lehrer, Sandusky, as alternate-delegate to Dr. Wiseley for a term of one year, namely, 1948. There being no further nominations, on motion duly made, seconded, and unanimously carried, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Wiseley and Dr. Lehrer. This was done and they were declared duly elected delegate and alternate to the American Medical Association for the year 1948.

PROPOSED AMENDMENT

Dr. Emil R. Swepston, Cincinnati, then presented the following statement and proposal on behalf of the Nominating Committee:

"Your Nominating Committee desires to submit a proposed amendment to that section of the By-Laws of the Association relative to filling vacancies in office occurring between Annual Meetings. It believes that the present section is ambiguous.

"It suggests that the last sentence of Chapter 8, Section 7, of the By-Laws, which provides that The Council shall fill vacancies, shall be amended to read as follows:

"The appointee shall serve until the next Annual Meeting of the House of Delegates, at which time the office shall be filled as provided for in the Constitution and By-Laws."

"To meet the provisions relative to amending the By-Laws, this proposed amendment cannot be voted upon until the Annual Meeting in 1949, but is herewith submitted for consideration by the House of Delegates at the 1949 Annual Meeting."

On motion duly made, seconded, and unanimously carried, the recommendation of the Nominating Committee, proposing an amendment to the By-Laws, was received by the House of Delegates and ordered placed on the agenda for consideration at the 1949 Annual Meeting, after proper publication in *The Journal* as provided for in the Constitution and By-Laws.

DR. BRINDLEY INSTALLED

At this point Dr. Rutledge installed Dr. A. A. Brindley, Toledo, into office as President of the

Association for the ensuing year, presenting him with the official gavel.

Dr. Brindley announced the following appointments to the standing committees of the Association provided for in the By-Laws, and designated the chairman of each committee as indicated for the ensuing year.

COMMITTEE APPOINTMENTS

Committee on Public Relations and Economics—Dr. D. W. Heusinkveld, Cincinnati, for a term of five years. Dr. James G. Kramer, Akron, a member of the committee, to serve as chairman for the ensuing year.

Committee on Education—Dr. Edwin P. Jordan, Cleveland, for a term of five years. Dr. Carl A. Wilzbach, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—Dr. J. E. Tuckerman, Cleveland, for a term of five years. Dr. John A. Caldwell, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—Dr. Frank W. Anzinger, Springfield, for a term of five years. Dr. Louis G. Herrmann, Cincinnati, a member of the committee, to serve as chairman for the ensuing year.

On motion duly made, seconded, and unanimously carried, the foregoing appointments by President Brindley were confirmed by the House of Delegates.

QUESTION REFERRED TO COMMITTEE

Under the item of new business, Dr. Ross M. Knoble, Sandusky, moved that the question covered by Resolution J, which had been laid on the table by action of the House of Delegates, be referred to the Committee on Education for study and a report to The Council, and that The Council submit its findings and recommendations, based on the committee's report, to the House of Delegates at the 1949 Annual Meeting. The motion was seconded by Dr. L. E. Anderson, Greentown, and was carried by a majority vote of the House of Delegates.

VOTE OF APPRECIATION

Dr. J. W. Conwell, Cleveland, offered the following motion that the House of Delegates officially extend a vote of thanks and sincere appreciation to the officers of the State Association, Section Officers, Committee on Scientific Work, Committee on Scientific Exhibit, Woman's Auxiliary, Cincinnati Academy of Medicine, the Cincinnati hotels, the local committees on arrangement, the radio stations, and the newspapers for their kindnesses and wholehearted cooperation and support in making this meeting one of the most successful from the standpoint of interest, instruction, and entertainment in the history of the

Association. The motion was seconded by many delegates and unanimously carried.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary.

HOUSE OF DELEGATES ROLL CALL—1948 MEETING

County	Delegate	First Session	Second Session
FIRST DISTRICT			
ADAMS	S. J. Ellison	Present	Present
BROWN	H. M. Lowell	Present	Present
BUTLER	C. T. Atkinson	Present	Present
CLERMONT	A. J. Mastropaolo	Present	Present
CLINTON	Edmond K. Yantes	Present	Present
HAMILTON	William J. Graf	Present	Present
	Emil R. Swepston	Present	Present
	A. Clyde Ross	Present	Present
	William A. Altemeier	Present	Present
	C. R. Deeds	Present	Present
	Harry L. Fry	Present	Present
	Edward J. McGrath	Present	Present
	Stanley D. Simon	Present	Present
	Arthur W. Wendel	Present	Present
	Robert H. Kotte	Present	Present
	Joseph Lindner	Present	Present
HIGHLAND	John G. Anderson	Present	Present
WARREN	O. L. Layman	Present	Present
SECOND DISTRICT			
CHAMPAIGN	D. C. Houser	Present	Present
CLARK	D. W. Hogue	Present	Present
DARKE	J. E. Gillette	Present	Present
GREENE	C. G. McPherson	Present	Present
MIAMI	G. A. Woodhouse	Present	Present
MONTGOMERY	M. D. Prugh	Present	Present
	R. D. Dooley	Present	Present
	R. S. Binkley	Present	Present
	A. W. Carley	Present	Present
PREBLE	C. E. Newbold	Present	Present
SHELBY	H. E. Crimm	Present	Present
THIRD DISTRICT			
ALLEN	Fred P. Berlin	Present	Present
AUGLAIZE	Elizabeth Y. Kuffner	Present	Present
CRAWFORD	D. G. Arnold	Present	Present
HANCOCK	Frank M. Wiseley	Present	Present
HARDIN	F. M. Elliott	Present	Present
LOGAN	Hobart L. Mikesell	Present	Present
MARION	H. K. Mouser	Present	Present
MERCER	E. J. Willke	Present	Present
SENECA	R. F. Machamer	Present	Present
VAN WERT	Roy E. Shell	Present	Present
WYANDOT	C. B. Schoolfield	Present	Present
FOURTH DISTRICT			
DEFIANCE	D. J. Slosser	Present	Present
FULTON	E. R. Murbach	Present	Present
HENRY	Thomas Quinn	Present	Present
LUCAS	Foster Myers	Present	Present
	Rollin Kuebbeler	Present	Present
	Albert L. Bershon	Present	Present
	Oliver E. Todd	Present	Present
	R. A. Diethelm	Present	Present
OTTAWA	G. A. Boon	Present	Present
PAULDING	Ray Mouser	Present	Present
PUTNAM	W. B. Recker	Present	Present
SANDUSKY	A. C. Rini	Present	Present
WILLIAMS	H. R. Mayberry	Present	Present
WOOD	Paul F. Orr	Present	Present
FIFTH DISTRICT			
ASHTABULA	R. B. Wynkoop	Present	Present
CUYAHOGA	Chas. G. LaRocco	Present	Present
	W. F. Boukalik	Present	Present
	John H. Budd	Present	Present
	John W. Conwell	Present	Present
	Donald C. Darrah	Present	Present
	G. A. DeOreo	Present	Present
	Farrell T. Gallagher	Present	Present
	Charles L. Hudson	Present	Present
	J. H. Lazzari	Present	Present
	James T. Ledman	Present	Present
	Paul A. Mielcarek	Present	Present
	Fay A. LeFevre	Present	Present
	M. Paul Motto	Present	Present
	William E. Smith	Present	Present
	Ralph M. Watkins	Present	Present
	R. J. Whitacre	Present	Present

County	Delegate	First Session	Second Session
GEAUGA	Alton W. Behm	Present	Present
LAKE	Morris G. Carmody	Present	Present
SIXTH DISTRICT			
COLUMBIANA	J. A. Fraser	Present	Present
MAHONING	Wm. M. Skipp	Present	Present
	E. J. Wenaas	Present	Present
	G. G. Nelson	Present	Present
	R. E. Odom	Present	Present
PORTAGE	E. M. Kauffman	Present	Present
STARK	A. R. Basinger	Present	Present
	L. E. Anderson	Present	Present
	R. K. Ramsayer	Present	Present
	R. E. Pinkerton	Present	Present
SUMMIT	E. W. Burgner	Present	Present
	Kurt Weidenthal	Present	Present
	L. A. Witzeman	Present	Present
TRUMBULL	Harry A. Smith	Present	Present
SEVENTH DISTRICT			
BELMONT	Leo D. Covert	Present	Present
CARROLL	Joseph D. Stires	Present	Present
COSHOCTON	G. A. Foster	Present	Present
HARRISON	C. F. Goll	Present	Present
JEFFERSON	S. L. Burkhardt	Present	Present
MONROE		Present	Present
TUSCARAWAS	C. M. Dougherty	Present	Present
EIGHTH DISTRICT			
ATHENS	R. E. Main	Present	Present
FAIRFIELD	L. E. Stenger	Present	Present
GUERNSEY	James A. L. Toland	Present	Present
LICKING	George A. Gressle	Present	Present
MORGAN	Henry Bachman	Present	Present
MUSKINGUM	M. A. Loebell	Present	Present
NOBLE	C. F. Thompson	Present	Present
PERRY	M. P. Clouse	Present	Present
WASHINGTON	Ford Eddy	Present	Present
NINTH DISTRICT			
GALLIA	Francis Shane	Present	Present
HOCKING	C. T. Grattidge	Present	Present
JACKSON	John L. Frazer	Present	Present
LAWRENCE	W. F. Marting	Present	Present
MEIGS	R. E. Boice	Present	Present
PIKE	Charles L. Critchfield	Present	Present
SCIOTO	W. A. Quinn	Present	Present
VINTON	H. D. Chamberlain	Present	Present
TENTH DISTRICT			
DELAWARE	B. R. Lauer	Present	Present
FAYETTE	James E. Rose	Present	Present
FRANKLIN	Drew L. Davies	Present	Present
	George J. Heer	Present	Present
	Grant O. Graves	Present	Present
	Warren G. Harding, 2nd	Present	Present
	Charles W. Pavey	Present	Present
	F. C. Hugenberger	Present	Present
KNOX	Henry Lapp	Present	Present
MADISON	W. A. Holman	Present	Present
MORROW	F. M. Hartsook	Present	Present
PICKAWAY	Geo. W. Heffner	Present	Present
ROSS	Ralph W. Holmes	Present	Present
UNION	E. J. Marsh	Present	Present
ELEVENTH DISTRICT			
ASHLAND	A. D. Robertson	Present	Present
ERIE	V. A. Killoran	Present	Present
HOLMES	N. P. Stauffer	Present	Present
HURON	O. J. Nicholson	Present	Present
LORAIN	Leonard A. Stack	Present	Present
	S. D. Nielsen	Present	Present
MEDINA	T. V. Kolb	Present	Present
RICHLAND	John S. Hattery	Present	Present
WAYNE	F. C. Ganyard	Present	Present
OFFICERS			
President	R. L. Rutledge	Present	Present
President-Elect	A. A. Brindley	Present	Present
Past-President	Edgar P. McNamee	Present	Present
Treasurer	H. P. Worstell	Present	Present
COUNCILORS			
District	E. O. Swartz	Present	Present
First	H. C. Messenger	Present	Present
Second	J. Craig Bowman	Present	Present
Third	Carll S. Mundy	Present	Present
Fourth	Fred W. Dixon	Present	Present
Fifth	Paul A. Davis	Present	Present
Sixth	Carl A. Lincke	Present	Present
Seventh	Chester P. Swett	Present	Present
Eighth	Gilbert R. Micklethwaite	Present	Present
Ninth	H. M. Clodfelter	Present	Present
Tenth	Ross M. Knoble	Present	Present
Eleventh	Totals	121	121

Proceedings of The Council

Miscellaneous Business Transacted at Cincinnati on Eve of 1948 Annual Meeting and at Special Meeting

A regular meeting of The Council of the Ohio State Medical Association was held at the Netherland Plaza, Cincinnati, Monday evening, March 29, 1948, with a majority of the members of The Council present. The meeting followed the customary dinner at which past-presidents, delegates to the American Medical Association, chairmen of the standing committees of the Association, chairmen of the local annual meeting committees, and officials of the Cincinnati Academy of Medicine were guests of The Council.

The Executive Secretary reported membership statistics as follows: Total membership as of March 27, 1948—6,900, including 24 military members and 263 new members; compared to a total membership of 7,106 on December 31, 1947.

Final arrangements for the Annual Meeting, opening on Tuesday, March 30, were reviewed.

On motion by Dr. Davis, seconded by Dr. Brindley, and carried, The Council commended the Committee on Scientific Work and the Committee on Scientific Exhibit for the excellent program and exhibits which had been arranged.

SCIENTIFIC EXHIBIT AWARDS APPROVED

The question of awards for the best scientific exhibits was discussed. On motion by Dr. Bowman, seconded by Dr. Knoble, and carried, The Council authorized first, second, and third awards in the Scientific Exhibit, and the appointment by the President of a special committee to judge the exhibits and recommend the winners.

There was a discussion as to the form of the awards to be presented to the Scientific Exhibit winners. On motion by Dr. Bowman, seconded by Dr. Knoble, and carried, the incoming President was authorized to select a committee to study this matter and to submit recommendations to The Council, with the understanding that when the appropriate awards have been decided upon, they would be transmitted to those selected as the winners in this year's exhibit.

The Council also discussed the question of the Association owning its own scientific exhibit equipment, but this matter was deferred for future consideration.

There was a general discussion of the activities of the United States Congress and the plans for the National Health Assembly to be held in Washington, May 1-4. On motion by Dr. Brindley, seconded by Dr. Swartz, and carried, the Executive Secretary was authorized to attend the National Health Assembly.

REGARDING BOGOTA CONFERENCE

There was a general discussion of the Ninth International Conference of American States

now being held in Bogota, Columbia, South America. Dr. E. J. McCormick, Toledo, member of the Board of Trustees of the American Medical Association, commented on a proposal which will be considered at that conference, and which would put the American states on record as endorsing compulsory health insurance.

On motion by Dr. Knoble, seconded by Dr. Davis, and carried, The Council authorized the drafting of a resolution, requesting the American delegation to oppose that proposal, for presentation to the House of Delegates on Tuesday, March 30.

NATIONAL EMERGENCY MEDICAL SERVICE

Dr. C. C. Sherburne, Columbus, chairman of the Committee on National Emergency Medical Service of the Association, presented a brief report on the activities of his committee to date. He commented on a meeting which will be held at the A.M.A. Headquarters on April 5 and 6 on this matter, which meeting will be attended by Dr. Richard L. Meiling, Columbus, a member of the Ohio committee and secretary of the Council on National Emergency Medical Service of the A.M.A. Dr. Sherburne stated that his committee expects to have a meeting shortly after the A.M.A. conference.

A communication from Dr. John B. Youmans, University of Illinois College of Medicine, offering to provide *The Ohio State Medical Journal* with a review, "Medicine of the Year," prepared by members of the faculty of that school, and to be run as a supplement in the January issue of *The Ohio State Medical Journal* at a special subscription charge, was read and discussed. On motion by Dr. Davis, seconded by Dr. Swartz, and carried, The Council advised the Editor of *The Journal* that it was the opinion of The Council that it would not be feasible for *The Ohio State Medical Journal* to undertake this project.

A communication from the Cincinnati Academy of Medicine, reporting that the council of the Academy had approved a rheumatic fever program for that area to be carried on by the Crippled Children Services of the State Department of Public Welfare, was read and discussed. No action on the communication was taken by The Council.

SPECIAL SUB-COMMITTEE

At this point President Rutledge announced the appointment of a special sub-committee of The Council, as authorized at the last meeting of The Council, to investigate a controversy between the physicians in Summit County and an Akron

hospital on matters of staff privileges. The members of the special sub-committee, as appointed by Dr. Rutledge, are: Dr. E. O. Swartz, Cincinnati, Chairman, Dr. H. M. Clodfelter, Columbus, and Dr. J. Craig Bowman, Upper Sandusky.

A communication from Mr. Raymond R. Peck, secretary-treasurer of the Ohio Federation of Teachers, was read and discussed. The communication requested the support of the Association on a proposed amendment to the Constitution of the State of Ohio to provide for a permanent method of financing the public schools of Ohio by inserting definite wage provisions in the Constitution.

On motion by Dr. Davis, seconded by Dr. Clodfelter, and carried, The Council voted not to support the proposal, believing that questions of this kind should not be handled through constitutional amendment but by legislative action on the part of the General Assembly.

There being no further business, The Council then recessed to meet with the House of Delegates on Tuesday evening, March 30.

SPECIAL MEETING OF THE COUNCIL

A special meeting of The Council, called by the incoming President, Dr. A. A. Brindley, was held at the Netherland Plaza, Cincinnati, on Thursday afternoon, April 1, following the final session of the House of Delegates, with a majority of the members of The Council present.

Dr. Brindley advised The Council that the main purpose of the meeting was to obtain confirmation of special committee appointments for the ensuing year.

On motion duly made, seconded, and unanimously carried, the following committee appointments, submitted by Dr. Brindley, were approved.

Auditing and Appropriations—Dr. E. O. Swartz, Cincinnati, chairman; Dr. Fred W. Dixon, Cleveland; Dr. Carl S. Mundy, Toledo.

Woman's Auxiliary Advisory Committee—Dr. H. M. Clodfelter, Columbus, chairman; Dr. Paul A. Davis, Akron; Dr. J. Craig Bowman, Upper Sandusky.

Committee on Medical Care of Veterans—Dr. Herbert B. Wright, Cleveland, chairman; Dr. Robert Conard, Wilmington; Dr. Harry R. Huston, Dayton; Dr. Wm. W. Trostel, Piqua; Dr. W. Green, Toledo; Dr. Edgar Northrup, Marietta; Dr. Drew L. Davies, Columbus; Dr. John H. Marshall, Findlay; Dr. Gordon G. Nelson, Youngstown; Dr. Lewis W. Cellio, Columbus; Dr. Charles L. Shafer, Mansfield; Dr. L. D. Allard, Portsmouth; Dr. Robert L. Eastman, Mt. Vernon; Dr. E. H. Crawfis, Cleveland; Dr. T. H. Vinke, Cincinnati; Dr. A. L. Bershon, Toledo.

Committee on Rural Health—Dr. Carl S. Mundy, Toledo, chairman; Dr. Jonathan Forman, Columbus; Dr. W. B. Recker, Leipsic; Dr. E. G. Caskey, Mineral Ridge; Dr. Wm. B. Taylor, Jackson; Dr. James M. Snider, Marysville; Dr. H. T. Pease, Wadsworth; Dr. A. D. Harvey, Lebanon; Dr. L. E. Anderson, Greentown; Dr. H. R. Mayberry, Bryan; Dr. Edmond K. Yantes, Wilmington; Dr. J. Martin Byers, Greenfield; Dr. F. M. Hartsook, Cardington.

Sub-Committee on Legislation—Dr. G. A. Woodhouse, Pleasant Hill, chairman; Dr. Emil R. Swepston, Cincinnati; Dr. Wm. M. Skipp, Youngstown; Dr. Floyd M. Elliott, Ada; Dr. D. J. Slosser, Defiance; Dr. John M. Van Dyke, Canton; Dr. Jay W. Calhoon, Uhrichsville; Dr. R. G. Plummer, Newark; Dr. Clyde M. Fitch, Portsmouth; Dr. Donald F. Bowers, Columbus; Dr. George F. Linn, Norwalk.

Committee on Industrial Health and Workmen's Compensation—Dr. H. P. Worstell, Columbus, chairman; Dr. F. G. Barr, Dayton; Dr. Geo. F. Sykes, Cleveland; Dr. Robt. A. Kehoe, Cincinnati; Dr. Louis N. Jentgen, Columbus; Dr. John M. Van Dyke, Canton; Dr. James N. Wychgel, Cleveland; Dr. Warren A. Baird, Toledo.

Committee on Medical Service Plans—Dr. Robert C. Rothenberg, Cincinnati, chairman; Dr. Wm. M. Skipp, Youngstown; Dr. Jonathan Forman, Columbus; Dr. R. K. Finley, Dayton; Dr. Robert E. S. Young, Columbus; Dr. Carl S. Mundy, Toledo; Dr. Reyburn McClellan, Xenia; Dr. Azel Ames, Jr., Hamilton; Dr. Farrell T. Gallagher, Lakewood.

Committee on Cancer—Dr. C. E. Hufford, Toledo, chairman; Dr. John H. Lazzari, Cleveland; Dr. Carl A. Wilzbach, Cincinnati; Dr. L. A. Pomeroy, Cleveland; Dr. Robert M. Zollinger, Columbus; Dr. Robert T. Allison, Jr., Akron; Dr. Edgar P. McNamee, Cleveland.

Committee on Mental Hygiene—Dr. George T. Harding, Columbus, chairman; Dr. Neil T. McDermott, Cleveland; Dr. Louis J. Karnosh, Cleveland; Dr. Maurice Levine, Cincinnati; Dr. Milton Rosenbaum, Cincinnati; Dr. R. E. Pinkerton, Akron; Dr. Dwight M. Palmer, Columbus; Dr. O. M. Lawton, Youngstown; Dr. J. L. Sagebiel, Dayton; Dr. Elmer Haynes, Toledo; Dr. Frank F. Tallman, Columbus.

Committee on National Emergency Medical Service—Dr. C. C. Sherburne, Columbus, chairman; Dr. Robert Conard, Wilmington; Dr. Cyrus R. Wood, Port Clinton; Dr. Carl R. Damron, Mansfield; Dr. Robert M. Zollinger, Columbus; Dr. Harry R. Huston, Dayton; Dr. W. O. Ramey, Cincinnati; Dr. Richard L. Meiling, Columbus; Dr. E. A. Ockuly, Toledo; Dr. Claude S. Perry, Columbus; Dr. Drew L. Davies, Columbus; Dr. Robert E. Tschantz, Canton; Dr. Maurice M.

Kane, Greenville; Dr. Fred Berlin, Lima; Dr. William J. Graf, Cincinnati.

Committee on School Health—Dr. Carl A. Wilzbach, Cincinnati, chairman; Dr. Thomas E. Shaffer, Columbus; Dr. J. W. Wilce, Columbus; Dr. C. W. Wyckoff, Cleveland; Dr. Charles T. Atkinson, Middletown; Dr. L. A. Hamilton, Athens; Dr. T. L. Light, Dayton; Dr. R. E. Shell, Van Wert; Dr. John F. Miller, Newark; Dr. Margaret O'Neal, Zanesville; Dr. F. A. Halloran, Springfield; Dr. H. B. Thomas, Gallipolis; Dr. Russell C. Bane, Chillicothe; Dr. J. M. Painter, Kent.

Pursuant to action by the House of Delegates, authorizing the selection of the time and place of the Annual Meeting three years in advance, The Council, on motion duly made, seconded, and unanimously carried, instructed the Executive Secretary to obtain tentative dates for the 1950 Annual Meeting in Cleveland and the 1951 Annual Meeting in Cincinnati, the House of Delegates having voted specifically to hold the 1949 Annual Meeting in Columbus the week of April 17.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Psychosomatic Seminar To Be Given at O.S.U.

A seminar in practical psychosomatic medicine for the benefit of the physicians of central Ohio and surrounding areas will be held on the first three Wednesday afternoons of June on the campus of Ohio State University. The seminar is being sponsored by the Division of Mental Hygiene of the Department of Public Welfare of Ohio and the Department of Neurology and Psychiatry of the University.

On June 2, at 1:30 p. m. in Campbell Hall, Dr. Edward Weiss of Philadelphia, will speak on "Practical Psychosomatic Medicine." Dr. Dwight M. Palmer, chairman of the Department of Neurology and Psychiatry, O. S. U., will speak on "Psychosomatic Profiles in Diagnosis and Treatment." Dr. N. O. Rothermich, O. S. U. College of Medicine, will speak on "Psychosomatic Factors in Rheumatoid Arthritis."

On June 16, in University Hall, Dr. Harold G. Wolff, New York City, will speak on "The Psychosomatic Aspects of the Gastro-Intestinal System." Dr. John Mitchell, O. S. U. College of Medicine, will speak on "The Psychosomatic Aspects of Allergy."

The program for June 9 will be announced later. All practitioners of medicine are invited without registration fee.

"Grass Roots" Conference for Local Society Officers, June 20

"The Job of the County Medical Society" will be the theme of the Third National Conference of County Medical Society Officers, to be held Sunday, June 20, Palmer House, Chicago, one day prior to the opening of the 97th Annual Meeting of the American Medical Association.

Registration for the conference will begin at 1:30 p.m., and the first of three panel discussions which constitute the program will be held from 2:00 to 2:45 p.m. Entitled "The County Medical Society—Its Part in Medical Organization," this session will cover the county society's relationship to the State Medical Association; the American Medical Association; and to other organizations including the Academy of General Practice, Blue Shield, etc. The discussant will be Dr. F. J. Holroyd, Princeton, West Virginia, and a question and answer period will follow.

The second panel will take up "The County Medical Society—Its Responsibility to the Membership." This subject will be divided into "Organization Responsibilities," including selection and maintenance of membership, maintaining ethics, and relations with hospitals; "Scientific Programming"; and "Fellowship and Business," including social functions and business aids. Discussants will be Dr. T. J. Danaher, Torrington, Connecticut; Dr. C. J. Milling, Columbia, South Carolina; and Dr. C. L. Mulfinger, Los Angeles, respectively.

The third and final panel discussion, "The County Medical Society—Its Responsibility to the Public," beginning at 4 p.m., will be divided into four parts. The first, "Medical Care—Serving the Public," will deal with pay patients, medically indigent, and indigent-government clients. The discussant will be Dr. D. B. Wiley, Utica, Michigan.

The second subdivision of this panel is entitled "Community Agencies—The Growing Demand of These Agencies Requires Serious Consideration," and will include a review of special programs on cancer, tuberculosis, heart, and others; community chest drives; and health councils. Dr. W. E. Nissen of Albuquerque, and Dr. B. O. Mork, Jr., Worthington, Minnesota, are the discussants.

"Newspapers, Radio, Industry, and Labor," are to be considered next, and the discussant is Dr. John D. Bibb of Reno, Nevada. The final topic will be "Legislative—Political Responsibilities of the County Medical Society," and the discussant is Dr. R. B. Robins, Camden, Arkansas.

Dr. George A. Woodhouse, Pleasant Hill, secretary of the Miami County Medical Society, is serving as State Chairman for Ohio.

Presenting . . .

The New President-Elect and Other Officers Elected To The Council at the Annual Meeting

FOLLOWING are biographical sketches of the new President-Elect and new members of The Council, elected by the House of Delegates of the Ohio State Medical Association, at the 1948 Annual Meeting, held in Cincinnati, March 30, 31, and April 1, and the incoming President, who was installed in office at the meeting.

Dr. Carl A. Lincke, of Carrollton, named President-Elect of the Ohio State Medical Association, is one of the youngest men ever to be chosen by his colleagues to the highest post in medical circles in Ohio. He is 43 years of age. As President-Elect he will serve on The Council and will assume the presidency at the Annual Meeting in Columbus next Spring.

During his more than 15 years of continuous practice in a town of 2,500 population, Dr. Lincke has acquired a reputation as a representative "country doctor." Though reared in a small city, Dr. Lincke chose to practice his profession in one of the most sparsely populated counties of the State, which even today does not have a hospital within its borders.

Dr. Lincke was born on Christmas Day, 1905, in Alliance, where he received his elementary and secondary education. He received his premedical and medical education at Ohio State University from which he graduated in medicine in 1931. Upon completion of a year's internship at White Cross Hospital, Columbus, he began practice in Carroll County.

For the past six years, Dr. Lincke has been a member of The Council of the Ohio State Medical Association, representing the Seventh District. Prior to being elected to that office, he was president of the Carroll County Medical Society and served for six years as secretary of the local society.

He was one of the founders of Ohio Medical Indemnity, Inc., and is a member of the Board of Directors and the executive committee of the plan. Also, he is one of Ohio's seven delegates to the American Medical Association. Dr. Lincke has served as chairman of the Auditing and Appropriations Committee and a member of the Committee on Extension of Activities.

Dr. Lincke is again serving as president of the Carroll County Medical Society. He is also active in other community affairs, is vice-president of the Cummings Bank at Carrollton, is a member of the Carrollton Rotary Club, the Masonic Lodge, the Elks, and of Nu Sigma Nu medical fraternity.

He is married and has a son and a daughter. His hobbies are mostly of the outdoor type and include hunting, fishing, and travel.



CARL A. LINCKE, M. D.

INCOMING PRESIDENT

Dr. A. A. Brindley, of Toledo, elected at the 1947 Annual Meeting in Cleveland, assumed the office as President for the coming year. Prior to his election, he was Fourth District Councilor for the Association since 1941.

Born in Swanton, Ohio, January 26, 1890, Dr. Brindley received his premedical education at West Virginia University, and received his M.D. degree from Jefferson Medical College, Philadelphia, in 1912.



A. A. BRINDLEY, M.D.

Dr. Brindley's active interest in organized medicine is indicated by successive offices he held in respective organizations where he carried on his practice. While located in Swanton, he served successively as secretary and president of the Fulton County Medical Society. In 1917, he moved his practice to Port Clinton, and again was successively secretary and president of the Ottawa County Medical Society.

Since 1924, he has been located in Toledo where he specializes in anesthesia, and is director of the department of anesthesia at St. Vincent's Hospital.

He was president of the Academy of Medicine of Toledo and Lucas County in 1943; has been a member of its council and board of trustees for seven years and chairman of the legislative committee; and represented the Academy in the House of Delegates for a number of years.

A fellow of the American Medical Association, Dr. Brindley is also a member of the American Society of Anesthetists, and a Fellow of the International College of Anesthetists. He is a member of the Lutheran Church, Kiwanis Club, various Masonic Orders, Elks Lodge, Toledo Club, and the Heatherdowns Country Club. During World War I, he served in the Army Medical Corps. He is married and the father of two grown children.

Besides his duties as Councilor and President-Elect, Dr. Brindley served as a member of the Association's Sub-Committee on Legislation, and was chairman of the Woman's Auxiliary Advisory Committee and a member of the Committee on Auditing and Appropriations.

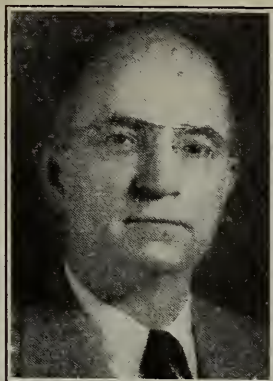
SEVENTH DISTRICT COUNCILOR

Newly elected Seventh District Councilor, to succeed Dr. Lincke, is Dr. Ruel J. Foster, of New Philadelphia.

Dr. Foster is a past-president and former sec-

retary of the Tuscarawas County Medical Society. He was born in Crawfordsville, Ind., Sep-

tember 6, 1896, the son of a physician. His son, Robert, is now an intern at City Hospital, Cleveland. His daughter, Lora, is a sophomore at Baldwin-Wallace College.



R. J. FOSTER, M.D.

Graduating from Wabash College in 1919, he received his M.D. degree from Western Reserve University School of Medicine in 1923, and completed his internship at St. Luke's Hospital, Cleveland.

Dr. Foster has practiced in New Philadelphia since 1924, and now limits his practice to general and gynecological surgery. His postgraduate work includes study at Harvard University.

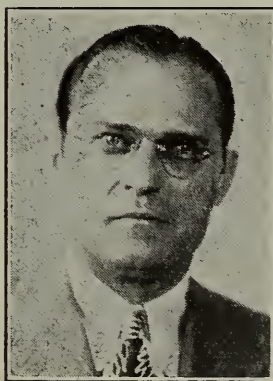
He is chief of staff and chief of surgery at Union Hospital, Dover, and in 1947 organized the local cancer detection clinic, of which he is chairman.

Dr. Foster is an elder in the Presbyterian Church, is a member of Masonic Orders including Aladdin Temple, and the New Philadelphia Elks and Rotary Club.

NINTH DISTRICT COUNCILOR

Successor to Dr. Gilbert Micklethwaite as Councilor of the Ninth District, is Dr. James P. McAfee, of Portsmouth.

Dr. McAfee was born in Danville, Ky., July 15, 1904. After receiving his medical education at the University of Louisville School of Medicine from which he graduated in 1931, he completed his internship at Grant Hospital, Columbus.



J. P. McAFEE, M.D.

During World War II, Dr. McAfee served three years with the Army Medical Corps. With the exception of those three years, he has been in general practice in Portsmouth since the completion of his internship. He is on the staffs of Mercy, Portsmouth General, and Smith-Everett Hospitals.

He holds memberships in Phi Beta Phi Medical Fraternity and Alpha Omega Alpha Honorary Medical fraternity. He is an elder in the Presbyterian Church, a director of the Ports-

mouth Y.M.C.A., and a member of the Kiwanis and Elks Clubs.

ELEVENTH DISTRICT COUNCILOR

Dr. John S. Hattery, Mansfield, was elected Eleventh District Councilor to succeed Dr. Ross M. Knoble, of Sandusky.



J. S. HATTERY, M.D.

He enrolled in the Starling Medical College in 1912 and received his M. D. degree in 1915 as a member of the first class to graduate under the merger of that College with Ohio State University. Subsequently he completed his internship at Protestant Hospital (now White Cross Hospital). He is a member of Phi Rho Sigma Medical Fraternity.

Immediately upon completion of his medical education, he became established in practice at Mansfield where he has been since, and where he early became a member of the Richland County Medical Society. He has taken an active interest in organized medicine, has served both as president and secretary of the local society, and was for many years a Delegate to the Ohio State Medical Association.

He acted on the Advisory Board of the Staff of Mansfield General Hospital for a period of years and is now chairman of a building commission, devoted to planning and building an 84-bed tuberculosis hospital.

Dr. Hattery is a member and past-president of the Mansfield Kiwanis Club, vice-president of the Westbrook Country Club, and is an honor member of Our Club. He was vice-president of his local school board, for a period of eight years, and is a past-trustee of the Mansfield Chamber of Commerce. During the war he served as an examiner on the Selective Service Board. He has served as president and secretary of both his fraternities. He is a member of the Presbyterian Church and the Masonic Lodge.

Dr. Hattery is married, has a son and a daughter and four grandchildren.

OTHER COUNCILORS

Councilors re-elected for another two-year term are the following: Dr. E. O. Swartz, Cincinnati,

First District; Dr. J. Craig Bowman, Upper Sandusky, Third District; Dr. Fred W. Dixon, Cleveland, Fifth District. Dr. Chester P. Swett, Lancaster, was elected to serve an unexpired term of one year. Dr. Swett was appointed by The Council to fill the unexpired term of Dr. Arthur J. Tronstein, Newark, from December until the session of the House of Delegates.

Other Councilors who are in the middle of their two-year terms are Dr. H. C. Messenger, Xenia, Second District; Dr. Carl S. Mundy, Toledo, Fourth District; Dr. Paul A. Davis, Akron, Sixth District; and Dr. H. M. Clodfelter, Columbus, Tenth District.

Army Discovers Moral Approach Gets Results on Venereal Disease

Army officials state that a moral approach to the sex problem has produced a phenomenal drop in the incidence of venereal disease among soldiers.

The training methods now being used successfully are the result of studies made in 1946 when the venereal disease rate in the Army, running parallel with the civilian rates, reached its highest peak during the entire war period.

Concepts used during the war which emphasized only the aspects of prevention have been supplemented by the new moral approach. The former implication that the individual was not remiss as long as his illicit sexual relations did not result in infection has been placed in the discard.

The new program is based on moral, spiritual, psychological as well as objective factors. Films on the subject used during the war have been junked, and new ones are being prepared to take their place.

Venereal disease for the Army as a whole decreased 4 per cent since January, 1947, and among soldiers in this country the decrease amounted to 50 per cent.

Army Winter Health Record High

The United States Army was in better health throughout the past Winter than during any like period in past years for which comparable statistics are available, according to the Army Medical Department.

Strictly comparable figures for the past quarter-century disclose an average January hospital admission rate in the Army of a little over 14 per 1000 troops per week, while the weekly rate for January, 1948, was 9.4 per 1000. The February, 1948, rate was 50 per cent lower than the average for the past 25 years; the rate this year was approximately ten-and-one-half cases of illness per 1000 troops per week, while the 25-year average was about fifteen-and-one-half per week.

1948 Annual Meeting in Cincinnati Demonstrates Expanding Tendency in Postwar Period

THE 1948 Annual Meeting of the Ohio State Medical Association in Cincinnati, March 30 to April 1, followed the postwar trend toward larger and more extensive meetings. The attendance, both of members and of visitors, closely approached the all-time record breaker of 1947 in Cleveland.

The number registered was 2,387, only 27 persons short of the total of 2,414 registered in Cleveland last year. A breakdown of the registration is given on page 528 of this issue.

EDUCATIONAL FEATURES

All sessions and events of the meeting were enthusiastically attended. The specialty section meetings, in spite of that early morning disadvantage proverbial at all conventions, drew exceptionally enthusiastic numbers. In several instances the sessions drew well over 160 physicians, with the average for all nine sections being more than 110 persons.

The 18 instructional courses drew overflow numbers in many instances, and without exception the courses were well attended. The instruction course feature, instituted at last year's meeting, has proved a definite attraction at the Annual Meeting. The moderators and their panels did an excellent job and succeeded in keeping the courses on a practical, informal basis.

General Sessions drew large numbers of physicians to the Hall of Mirrors where they heard scientific discussions by outstanding specialists from Ohio and other states.

Among the speakers at various sessions were 13 out-of-state guests, including some of the most outstanding physicians and surgeons in the country. These guest speakers gave Ohio physicians opportunity for an over-all view of what is being taught and practiced throughout the nation.

Many members remarked that the variety and quality of speakers and programs was one of the most educational experiences they had witnessed. The only regret of some was that they could not be in two places at the same time to hear more of the lectures and discussions.

COUNCIL AND HOUSE OF DELEGATES

Events of the week started with a special meeting of The Council Monday evening. Both sessions of the House of Delegates—Tuesday evening and Thursday afternoon—were attended by excellent representation of county societies. The roll call at both sessions showed 121 dele-

gates present. Minutes of these sessions appear elsewhere in this issue and should be read by all members.

BANQUET

Social highlight of the Annual Meeting was the banquet held Wednesday evening, March 31, in the beautiful Hall of Mirrors. The management of the hotel obligingly made place for approximately 70 more persons than the anticipated capacity, even to the point of placing tables in the foyer. Total banquet attendance was 780.

The custom of having the program principally entertainment proved a great success. Michael MacDougall, internationally-known card detective, gave an entertaining exhibition to convince most of his hearers that the "sucker" seldom has anything like an even break with the professional gamblers.

Dr. Ralph L. Rutledge, retiring president, was presented a replica of the official gavel used during his year in office by Dr. Edgar P. McNamee, past-president.

Following the elaborate dinner and special entertainment, members and their wives and guests enjoyed an evening of dancing to one of Cincinnati's top dance bands.

PUBLIC RELATIONS

The Annual Meeting was well publicized by press and radio. News releases prepared by the Association's Department of Public Relations were furnished to the wire services, the three Cincinnati newspapers—*Enquirer*, *Times-Star*, and *Post*—and to the news commentators on the five local radio stations, WLW, WSAI, WCKY, WKRC, and WCPO. In addition to local reporters, the meeting was covered by Walter Lerch of the *Cleveland Press* and Severino P. Severino of the *Cleveland News*.

Special radio programs included a five-minute resumé of the meeting each day at 11:15 a.m., by Dr. Carl A. Wilzbach, Cincinnati, chairman of the Committee on Education, on the program "The Woman's Side of the News" over WSAI. An interview with Dr. Ralph L. Rutledge, president of the Association, and Dr. Wilzbach, on the services of the Association to the public and the medical profession, was presented on WLW's Sylvia program, 6 to 6:15 p.m., Monday, March 29. A description of the Annual Meeting and the 25-point health program for Ohio was given by Syd Cornell on his program entitled "Between You and Me," Thursday morning, 11:15 to 11:30, over WKRC. A walkie-talkie description of the Scientific Exhibit in lay terms was given by Dr.

Wm. F. Ashe, chairman of the Committee on Scientific Exhibit, and Jim Gaylord, special services announcer for WLW, recorded and re-broadcast from 6 to 6:15 p. m., Friday, April 2.

SCIENTIFIC EXHIBIT

The elaborate Scientific Exhibit, where 39 separate exhibits on various medical studies were presented was one of the most successful of its kind, and convinced officers that it had definitely established itself as a major feature of the Annual Meeting. The Scientific Exhibit Committee, headed by Dr. Wm. F. Ashe, Cincinnati, won many compliments. An article listing those winning awards appears elsewhere in this issue.

NEW SECTION OFFICERS

At the meetings of Scientific Sections of the Ohio State Medical Association held during the Annual Meeting in Cincinnati the following officers were elected:

Section on Anesthesiology—Dr. Carl R. Damron, Mansfield, chairman, to succeed Dr. R. J. Whitacre, of East Cleveland; and Dr. George F. Collins, Columbus, to succeed Dr. Damron as secretary.

Section on Eye, Ear, Nose and Throat—Dr. Horace W. Reid, Cincinnati, was elected chairman to succeed Dr. Russel G. Means, Columbus; and Dr. Norvil A. Martin, Gallipolis, was elected to succeed Dr. Reid as secretary.

Section on General Practice of Medicine—Dr. Ross M. Knoble, Sandusky, was elected chairman to succeed Dr. Emil R. Swepston, Cincinnati; and Dr. J. G. Lemmon, Akron, was re-elected secretary.

Section on Medicine—Dr. Leon Schiff, Cincinnati, was elected chairman to succeed Dr. Ralph M. Watkins, Cleveland; and Dr. Fay A. LeFevre, Cleveland, was elected to succeed Dr. Schiff as secretary.

Section on Nervous and Mental Diseases—Dr. Dwight M. Palmer, Columbus, was elected chairman to succeed Dr. Philip Piker, Cincinnati; and Dr. John M. Flumerfelt, Cleveland, was elected to succeed Dr. Palmer as secretary.

Section on Obstetrics and Gynecology—Dr. Richard D. Bryant, Cincinnati, was elected to succeed Dr. J. L. Reyecraft, Cleveland, as chairman; and Dr. Allan C. Barnes, Columbus, was elected to succeed Dr. Bryant as secretary.

Section on Pediatrics—Dr. John Edwin Brown, Jr., Columbus, was elected chairman to succeed Dr. W. B. Taggart, Dayton; and Dr. Charles L. Shafer, Mansfield, was elected to succeed Dr. Brown as secretary.

Section on Public Health and Preventive Medicine—Dr. Thomas E. Shaffer, Columbus, was elected chairman to succeed Dr. Harold J. Knapp, Cleveland; and Dr. Marion G. Fisher, Oberlin, was elected to succeed Dr. William B. Wild, Massillon, as secretary.

Section on Surgery—Dr. Robert M. Zollinger, Columbus, was elected chairman to succeed Dr. J. Edwin Purdy, Canton; and Dr. John W. Holloway, Cleveland, was elected to succeed Dr. Zollinger as secretary.

HIGHLIGHTS AND SIDELIGHTS

Dr. D. W. Heusinkveld, Cincinnati, president-elect of the Cincinnati Academy of Medicine,

officially represented the host organization in calling the meeting of the House of Delegates to order and welcoming delegates to Cincinnati. Dr. M. A. Blankenhorn, president of the Academy and general chairman of the local arrangements committee, was unable to be present and sent his regrets.

* * *

Columbus was chosen by the House of Delegates as the place of the 1949 Annual Meeting. Dr. H. M. Clodfelter, president of the Columbus Academy of Medicine, issued the invitation in behalf of his Academy, the Columbus Chamber of Commerce, the Columbus Hotels and the Convention Bureau. The meeting is scheduled for the week of April 17.

* * *

Dr. D. C. Houser, Urbana, celebrated his 81st birthday on April 1 at the Annual Meeting, where he was an official delegate for the 46th year. Dr. Houser has practiced medicine for 51 years and has attended 50 consecutive Annual Meetings. He was given a rising vote of congratulations by the House of Delegates.

* * *

The Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association proved to be one of the largest and most successful ever held. Meetings of the Auxiliary were held at the Sinton Hotel. A complete report of the newly elected officers and actions taken at the meeting are reported elsewhere in this issue.

* * *

The House of Delegates resolved that whenever possible all resolutions for consideration by the House of Delegates shall be submitted to the Columbus Headquarters Office sufficiently in advance of the Annual Meeting to permit publication in an issue of *The Ohio State Medical Journal* which will appear at least 30 days before the meeting.

* * *

Total membership of the Ohio State Medical Association as of March 27, 1948, was 6,900, including 24 military members and 263 new members, Charles S. Nelson, Executive Secretary, reported to The Council. The membership on December 31, 1947, was 7,106. The current figure shows a high average of paid-up members for so early in the year, and indicates a tendency on the part of the majority of members to renew their memberships immediately. The official tabulation as of March 31 showed 6,919, and per-

haps 30 more have been added since. The paid-up membership on a comparable date last year was 6,279 with 74 military members.

* * *

A corps of personnel was kept busy during the Annual Meeting relaying telephone messages to physicians. The service was capably handled through the guidance of Ray A. Swink, executive secretary of the Cincinnati Academy, perhaps to the disquietude of some doctors who came to the meeting with the hope of getting away from the telephone.

* * *

Technical exhibitors lived up to expectation in furnishing some excellent displays as "side shows" to the Big Event. Due to limited space, the number of technical exhibits was limited to 50. Many additional companies applied to exhibit, but had to be turned down. It is hoped that more exhibit space will be available at future meetings. Physicians found an educational assortment of pharmaceuticals, equipment, books, and the like, and many of the exhibitors expressed gratitude at the interest taken.

* * *

Many committee members and others with official responsibilities at the Annual Meeting expressed appreciation for the all-out effort on the part of the Netherland Plaza management and personnel to keep their end of convention details running smoothly and efficiently. Whether it was supplying an extra table where needed, or clearing the dance floor after the banquet, hotel personnel were "Johnny-on-the-spot."

The personnel of the Gibson Hotel, where a number of meetings were held, likewise were unusually cooperative in making members and officials "want to come back to Cincinnati."

* * *

Among the scientific exhibits was one sponsored by the State Association, featuring the "Guidepost" booklet, ready reference catalogue of services offered to members by the Association's Headquarters Office.

Panels which accompanied six-foot enlargement of the service booklet cover, included description of the personal services of the Association; its public relations program; services to county medical societies; representation on the legislative fronts in Columbus and Washington; liaison with government agencies; sponsorship of Ohio Medical Indemnity, Inc., the "Doctors' Plan," and publication of *OSMagram* and *The Ohio State Medical Journal*.

Attendants at the booth accepted orders for various quantities of health education booklets for use in aiding the health education of patients. An assortment of 28 titles was offered free to members of the Ohio State Medical Association.

CHEST PHYSICIANS ELECT

At the Annual Meeting of the Ohio Chapter, American College of Chest Physicians, on March 31 at Hotel Gibson, the following officers were elected: Dr. William J. Habeeb, Springfield, President, to succeed Dr. W. L. Potts, Columbus; Dr. Garry G. Bassett, Lakewood, Vice-President, to succeed Dr. Habeeb; and Dr. Everett F. Conlogue, Dayton, to succeed Dr. Bassett as Secretary-Treasurer.

RADIOLOGICAL SOCIETY OFFICERS

The Ohio State Radiological Society convened for its Annual Meeting in the Gibson Hotel on March 31, and named the following officers: Dr. Henry Snow, Dayton, President, to succeed Dr. Ralph W. Holmes, of Chillicothe; Dr. Edward L. Voke, Akron, to succeed Dr. Snow as Vice-President; and Dr. Carroll C. Dundon, Cleveland, re-elected secretary-treasurer.

Dr. Forman Named President-Elect Of Allergists' College

Dr. Jonathan Forman, Columbus, editor of *The Ohio State Medical Journal*, was chosen president-elect of the American College of Allergists at its New York meeting in mid-March. Dr. Forman for the past two years had been a member of the Board of Regents of the organization.

Dr. George E. Rockwell, Milford and Cincinnati, assumed office as president of the organization. Dr. John H. Mitchell, Columbus, continues as a member of the Board of Regents.

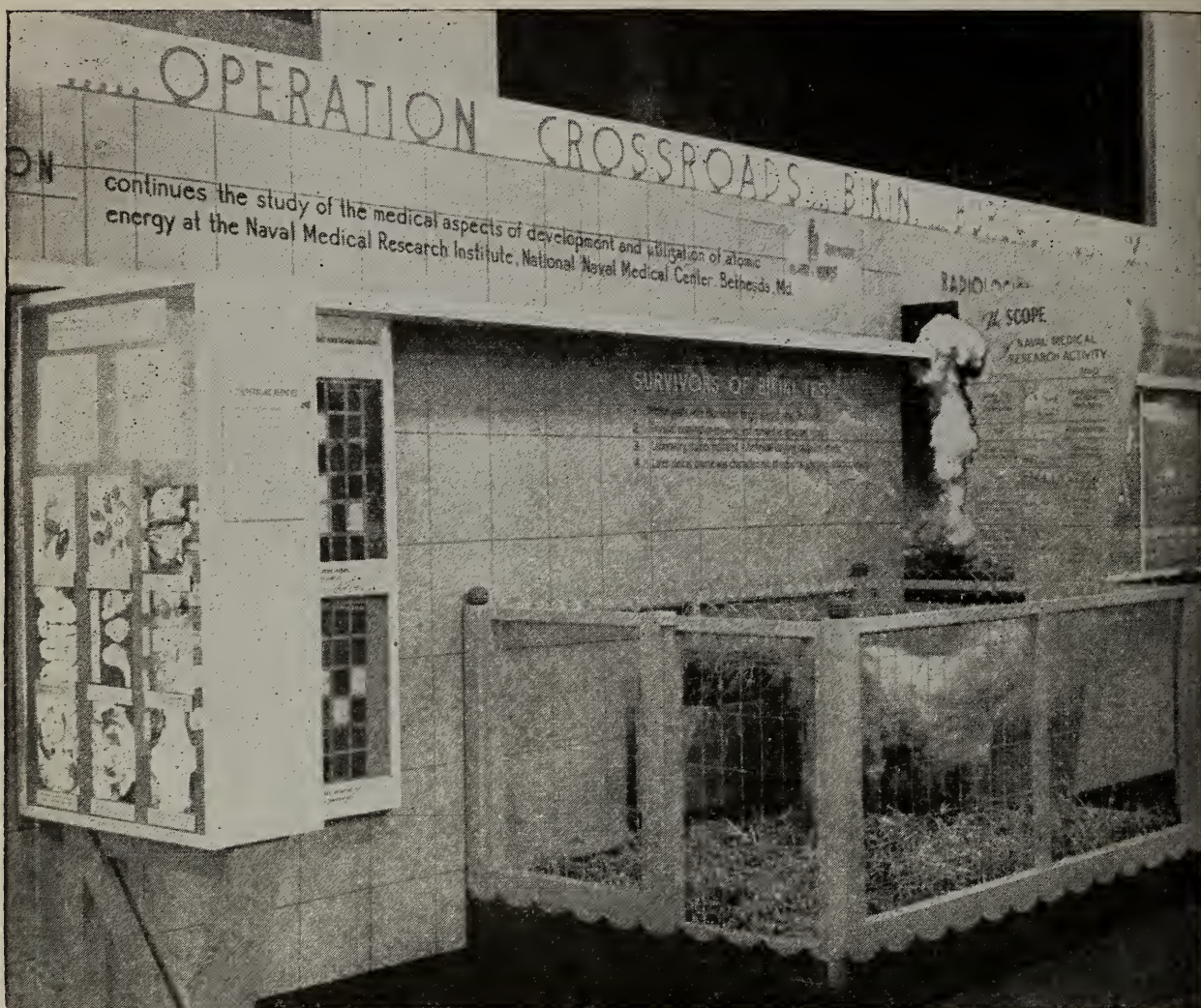
Ensminger Conviction Upheld by Supreme Court

The Ohio Supreme Court in a recent decision reversed the judgment of the Court of Appeals thereby upholding the conviction of G. R. Ensminger, Norwalk, on a charge of practicing medicine without a license by the Huron County Court of Common Pleas.

Ensminger was convicted in the Court of Common Pleas on information filed in December, 1946, under Section 12694 of the General Code. The case was appealed on the basis that the State, over the objection of Ensminger, introduced evidence that Ensminger had been previously convicted in six separate cases on charges of practicing medicine without a license. The Court of Appeals reversed the decision of the lower court.

The Supreme Court held that "such evidence (of former convictions) indicated the 'motive,' the 'intent,' the 'scheme, plan, or system' and the absence of mistake or accident in doing the act in question, within the meaning of Section 13444-19, General Code, and was admissible for that purpose."

Three Award Winners in Scientific Exhibit Named; Committee Commended for Successful Feature at Annual Meeting



"Satan" and "Adolph," only surviving goats of the atomic bomb explosion at Bikini, comprised only one feature of the U. S. Navy's exhibit on "Operation Crossroads," which in turn was only one of many interesting scientific exhibits. The Army and Air Corps also were represented with valuable medical exhibits.

ONE of the most popular and instructive features of the 1948 Annual Meeting was the Scientific Exhibit, which was efficiently and comfortably housed in the Netherland Plaza's Pavillon Caprice.

There were 39 displays, ranging from those which were of great practical value, medically speaking, to those showing the activities of some of the governmental agencies and where personnel of the agencies were on hand to furnish information and advice on the medical aspects of their work.

By action of The Council, a special committee was named to review the exhibits and to recommend awards. This was done and the awards recommended were officially approved by the House of Delegates on the final afternoon of the meeting.

First award went to Dr. Douglas P. Graf, Department of Surgery, Cincinnati General Hospital, for his display on the "Papanicolaou Technique."

The exhibit, "Cerebral Angiography," by Dr. Frank H. Mayfield, Dr. Edgar S. Lotspeich, Jr., and Dr. James R. Simpson, Cincinnati, received the second award.

Award No. 3 was taken by the Gastric Laboratory, Department of Internal Medicine and Department of Pathology, Cincinnati General Hospital, sponsor of an exhibit on "Punch Biopsy of the Liver."

The displays by the governmental agencies were not considered for the first, second, and third awards but all of them were given honorable mention and a vote of appreciation by the House of Delegates.

Special honorable mention citations were made to Dr. G. M. Guest, Dr. W. Brodsky, and Mrs. J. Garvin, Children's Hospital, Cincinnati, for their exhibit, "Juvenile Diabetes: Management With Unrestricted Dietary Regime," and to Dr. Joseph L. Morton, Dr. G. A. Erhard, and Dr. T. E. Fox, Ohio State University College of Medicine, Columbus, for their display entitled, "Radiographic Aids in Hematology."

By special action, the House of Delegates gave a special vote of commendation and appreciation to the Committee on Scientific Exhibit not only for its judgment in the selection of the displays presented but also for the efficiency displayed in the handling of all details in connection with the exhibit.

Dr. William F. Ashe, Kettering Institute of Applied Physiology, University of Cincinnati, was chairman of the committee. Due to excellent management and supervision on his part, before and during the meeting, plus the high quality of the exhibits in general, the 1948 Scientific Exhibit was without any doubt the finest ever presented by the Association. Dr. Ashe was ably assisted by the following committee members: Dr. Eugene B. Ferris, Department of Medicine, University of Cincinnati; Dr. Jean M. Stevenson, Department of Surgery, University of Cincinnati; Dr. Edward J. McGrath, Department of Surgery, University of Cincinnati; Dr. Morton Hamburger, Jr., Department of Medicine, University of Cincinnati; Dr. A. Carlton Ernstene, Cleveland Clinic, Cleveland; and Dr. Emmerich von Haam, Department of Pathology, Ohio State University.

The Council, sensing the enthusiasm of many who attended the meeting for scientific and educational displays, has decreed that the Scientific Exhibit should be a basic feature of each Annual Meeting and that suitable awards should be given annually to those presenting displays of outstanding importance and of practical value.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since February 11, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY

Richard L. Johnson, Lima
Robert M. Johnson, Lima

ATHENS COUNTY

Clarence E. Harco, Athens

BUTLER COUNTY

Max L. Durfee, Oxford
Rolfe A. Heck, Oxford
William A. McClellan, Oxford
Glenn L. Miller, Middletown

William D. Patton, Middletown

Elmer G. Sternberg, Hamilton

CLARK COUNTY

John A. Davidson, Springfield

COLUMBIANA COUNTY

Charles F. Kissinger, East Palestine

COSHOCTON COUNTY

Alfred H. Magness, Coshocton

CRAWFORD COUNTY

Donald R. Wenner, Bucyrus

CUYAHOGA COUNTY

Robert L. Alexander, Cleveland
Jack H. Bowen, Cleveland
Ben S. Brown, Cleveland
John M. Cook, Cleveland
Leonard B. Greentree, Columbus
Arthur G. Grosco, Cleveland
H. H. Hardesty, Cleveland
John S. Landes, Cleveland
Emmett J. O'Malley, Cleveland
Samuel Spector, Cleveland
Sam G. Stubbins, Cleveland
Martin R. D. Sutler, Jr., Cleveland
Stephen Toth, Cleveland
Lewis W. Whiting, Cleveland

FAYETTE COUNTY

H. Wm. Payton, Jeffersonville

FRANKLIN COUNTY

Robert L. Anderson, Columbus
William H. Benham, Columbus
Maurice G. Buckles, Columbus
Frederick J. Ebstein, Columbus
Joseph M. Gallen, Columbus
James L. Henry, Grove City
Stanley O. Hoerr, Columbus
Henry G. Hughes, Columbus
Hugh B. Hull, Jr., Columbus
Jacob J. Jacoby, Columbus
Arthur G. James, Columbus
Bruce Carson Martin, Columbus
Robert Gillespie Smith, Columbus
Elwyn M. Smolen, Columbus
Merrill E. Speelman, Columbus
George T. Stine, Columbus
Zana Jones-Dietz Vaile, Columbus
Ben R. Wiltberger, Columbus

HAMILTON COUNTY

Glenn D. Crook, Cincinnati
Edward P. Drohan, Cincinnati
Benjamin Lee Hawkins, Cincinnati
Carl J. Hochhausler, Cincinnati
Carl G. Hoffman, Cincinnati
Wm. P. Mulvaney, Manila, P.I.
Daniel Osher, Cincinnati
Robert R. Pierce, Cincinnati
Walter L. Pritz, Cincinnati
Edmund Rothfeld, Cincinnati
Julian S. Schneider, Cincinnati
Harold R. Tharp, Wyoming
C. Merle Welch, Harrison
Orville W. Winters, Cincinnati

HARDIN COUNTY

Robert T. Maurer, Kenton

KNOX COUNTY

J. W. Allman, Centerburg
John C. Woodland, Mt. Vernon

LORAIN COUNTY

Kenneth H. Willard, Elyria

LUCAS COUNTY

David T. Curtis, Toledo
Walter Greenon, Toledo
Henry D. Hopple, Toledo
Ward C. Meyers, Toledo
J. A. Provenzano, Toledo
A. E. Rhoden, Toledo
Morris Weinblatt, Toledo

MAHONING COUNTY

Louis Bloomberg, Youngstown
Kenneth E. Camp, Lowellville
Sidney Franklin, Youngstown
Sidney C. Keyes, Youngstown
John R. LaManna, Youngstown
S. W. Ondash, Youngstown
Stewart G. Patton, Jr., Youngstown
Charles Waltner, Youngstown

MONTGOMERY COUNTY

Malcolm Block, Dayton
Edward F. Buyniski, Dayton
Nathaniel L. Hollister, Dayton
Fenton J. Lane, Dayton
Neal C. Perkins, Dayton
Richard J. Schneble, Dayton
Wm. D. Welton, Dayton

MUSKINGUM COUNTY

Paul A. Jones, Zanesville

RICHLAND COUNTY

C. Karl Kuehne, Mansfield
Albert H. Voegelé, Mansfield

SANDUSKY COUNTY

Lee H. Moore, Fremont

SCIOTO COUNTY

Woodrow W. Scott, Portsmouth

SENECA COUNTY

Warren E. Bradbury, Tiffin

SHELBY COUNTY

Chauncey M. Gillespie, Jackson Center

STARK COUNTY

Thomas N. Davis, Massillon
Donald G. Henderson, Canton
Milton F. Jones, Massillon

SUMMIT COUNTY

Thomas S. Brownell, Akron
Robert E. Brubaker, Akron
S. R. DeMeter, Akron
A. L. Leiby, Akron
Louis F. Lombardi, Akron

TRUMBULL COUNTY

George S. Larson, Warren

TUSCARAWAS COUNTY

Edgar Davis, Jr., Dover
M. W. Johnson, New Philadelphia

Woman's Auxiliary Holds Annual Meeting; New Officers and Directors Elected

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

THE Woman's Auxiliary to the Ohio State Medical Association held its Eighth Annual Meeting, Tuesday, March 30, through Thursday, April 1, 1948, at the Hotel Sinton, Cincinnati. Mrs. Dale P. Osborn and Mrs. Paul Woodward, co-chairmen for the convention, left nothing undone to make the 1948 Annual Meeting an outstanding one.

On Tuesday, a pre-convention Board meeting was held. At this time the annual reports of officers and chairmen were given.

The Presidents' Luncheon on Tuesday was one of the outstanding events of the convention. The Past-Presidents of the Woman's Auxiliary to the Ohio State Medical Association; Presidents and Presidents-Elect of State Auxiliaries of neighboring States; and Mrs. Eustace A. Allen, President of the Woman's Auxiliary to the American Medical Association, were all seated at the speakers' table and introduced. Mrs. Allen was the guest speaker.

The formal opening of the House of Delegates followed the luncheon. Mrs. Harold K. Mouser presided. The invocation was given by Rev. Robert Netting, D.D. The Pledge of Loyalty was given by the officers and delegates. Mrs. Paul Woodward, co-chairman of the convention and President of the Woman's Auxiliary, Hamilton County, gave the address of welcome. Mrs. G. A. Gressle, Newark, Licking County, gave the response for the convention. The President, Mrs. Harold K. Mouser, addressed the group and asked each of the Board members to take a bow as she gave her year in review.

COUNTY REPORTS GIVEN

On Wednesday the second session of the House of Delegates was called to order by the president, Mrs. Mouser. Interesting reports were given by the county presidents at this time. Visual reports of projects of some of the county auxiliaries were given.

MRS. GILLETTE HONORED

The luncheon on Wednesday was in honor of Mrs. E. Benjamin Gillette, President-Elect. The speaker was Rev. Laurence H. Hall who spoke on "The Therapeutic Value of Laughter."

Surprises had been planned for each auxiliary member attending both the Tuesday and Wednesday luncheons, and every place at the tables was filled. The surprise at the Wednesday luncheon was a skit presented by members of the Hamilton

County Auxiliary. The highlight of the skit was the parody on the song, "The Girl That I Marry." This part of the program made members feel that they have an important role as doctors' wives.

"IN MEMORIAM"

At the White Breakfast on Thursday, an impressive memorial service for deceased auxiliary members was conducted by Mrs. C. W. Kirkland, Bellaire, President-Elect. Mrs. Kirkland was assisted by Mrs. James S. Mills and Mrs. Carl T. Kirchmeier. A chorus from the Glee Club of the Jewish Hospital School of Nursing, directed by Mrs. Ernest Doulton, concluded the service by singing the "Lord's Prayer."

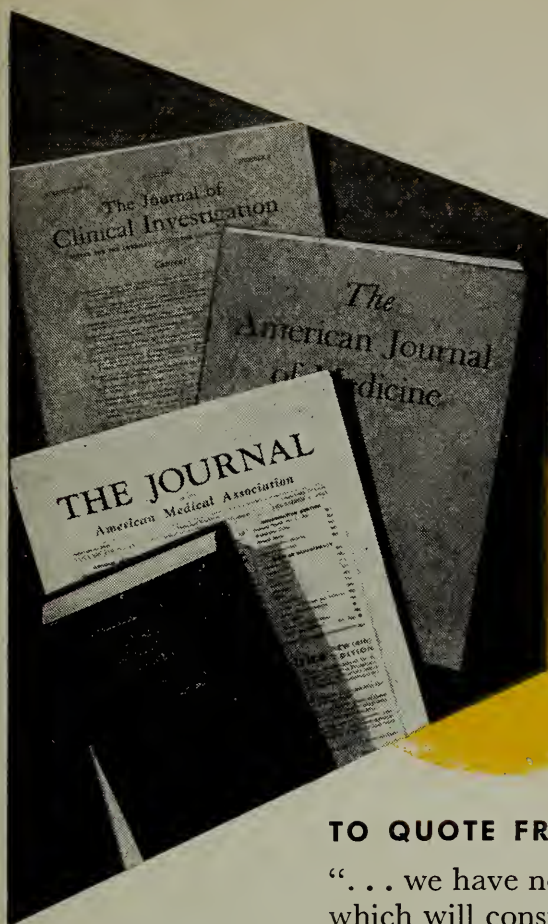
NEW OFFICERS AND DIRECTORS

The Third Session of the House of Delegates was called to order by the President. Delegates to the National Auxiliary Convention were elected. The announcement of the winners in the Credits and Awards contest was made. The Point System was used for the first time last year but many counties competed and liked the system very much. The first prize went to Clark County with 100 per cent, Mrs. E. Paul Greenawalt, Springfield, President; and the second prize to Ottawa County, with 90 per cent, Mrs. Cyrus Wood, Port Clinton, President.

A report of the nominating committee was presented by Mrs. Fred Brosius, Middletown, chairman. The following officers were elected: President-Elect, Mrs. C. W. Kirkland, Bellaire; Vice-President, Mrs. George W. Cooperrider, Columbus; Recording Secretary, Mrs. C. H. Bell, Mansfield; Corresponding Secretary, Mrs. Wilbur A. Taylor, Toledo; and Treasurer, Mrs. Robert H. Kotte, Cincinnati. Mrs. E. Benjamin Gillette, Toledo, assumed office as President, and Mrs. Harold K. Mouser, Marion, as Past-President.

Directors are: Mrs. Fred Brosius, Middletown; Mrs. E. Paul Greenawalt, Springfield; Mrs. Karl Ritter, Lima; Mrs. Cyrus Wood, Port Clinton; Mrs. William Eberle, Ashtabula; Mrs. James Bahrenburg, Canton; Mrs. D. H. Downey, Dover; Mrs. Chester Swett, Lancaster; Mrs. S. L. Meltzer, Portsmouth; Mrs. N. M. Reiff, Washington, C. H.

Chairmen of Standing Committees are: Finance, Mrs. Harold K. Mouser, Marion; Publicity, Mrs. Oscar W. Jepsen, Canal Winchester; *Hygeia*, Mrs. Ross Knoble, Sandusky; Program, Mrs. Harve M. Clodfelter, Columbus; Legislation, Mrs.



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CAUTION

Gold Sodium Thiosulfate must be used with extreme caution, especially in the presence of tuberculosis and diseases of the liver and kidneys.

1. Combined Staff Clinics of the College of Physicians and Surgeons, Columbia University: *Am. J. Med.* 1:675 (Dec.) 1946.

2. Comroe, B. I.: *J.A.M.A.* 128:848 (July 21) 1945.

3. Council of Pharmacy and Chem-

istry: *New and Nonofficial Remedies*, 1947, Philadelphia, J. B. Lippincott Company, 1947, p. 477.

4. Freyberg, R. H.; Block, W. D., and Levy, S.: *J. Clin. Investigation* 20:401 (July) 1941.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Paul A. Davis, Akron; Public Relations, Mrs. Farrell T. Gallagher, Lakewood; Historian, Mrs. Dale Osborn, Cincinnati; Organization, Mrs. C. W. Kirkland, Bellaire.

Chairmen of Special Committees are: Nurses' Scholarship Loan Fund, Mrs. Virgil Hauenstein, Cincinnati; Bulletin and Hand Book, Mrs. O. Reed Jones, Cambridge; Credits and Awards, Mrs. J. W. Calhoun, Uhrichsville; Radio and Visual Education, Mrs. Erling Smedal, Mansfield. Editorial Staff: Mrs. George W. Cooperrider, Columbus, Editor; Mrs. Harold K. Mouser, Marion; Mrs. Fred Brosius, Middletown; Mrs. Oscar W. Jepsen, Canal Winchester.

Mrs. Paul A. Davis, Akron, a Past-President, installed the officers. The convention adjourned after Mrs. E. Benjamin Gillette addressed the delegates and introduced the members of the new Board. A post-convention Board meeting and luncheon followed. The registration for the convention was 326.

NATIONAL AUXILIARY MEETING

Members are advised to make plans now to attend the twenty-fifth Annual Meeting of the Woman's Auxiliary to the American Medical Association which will be held June 21 to 25 in Chicago. Auxiliary headquarters will be on the mezzanine floor of the Hotel LaSalle.

Four new counties have recently been organized as follows: Defiance, Green, Lake, and Sandusky. The new officers of the Woman's Auxiliary to the Lake County Medical Society are: President, Mrs. G. O. Hedlund, Painesville; President-Elect, Mrs. H. S. Wells, Willoughby; Secretary, Mrs. G. R. Smith, Painesville; Treasurer, Mrs. Howard Stephens, Mentor; Recording Secretary, Mrs. James G. Powell, Painesville; Parliamentarian, Mrs. S. B. Park, Painesville. The newly elected officers of the Sandusky County Medical Auxiliary are: President, Mrs. Malcolm Riddell, Fremont; President-Elect, Mrs. Robert Fox, Greensprings; Secretary, Mrs. Lee H. Moore, Fremont; Treasurer, Mrs. Allen P. Newman, Fremont.

Two Ohio Doctors Included on West Virginia Program

Two Ohio physicians will be among those on the program at the Annual Meeting of the West Virginia State Medical Association, Huntington, May 10-12.

Dr. Henry M. Goodyear, Cincinnati, will discuss, "Some Practical Considerations in the Use of Chemotherapy and Antibiotics in the Treatment of Upper Respiratory Infections. Latent Mastoid Infections Following Their Use."

Dr. Russell L. Haden, Cleveland, will speak on "Gout."

Ohio Academy of General Practice Presented Charter

Dr. Joseph W. Linder, Cincinnati, was elected the first president of the Ohio Academy of General Practice, during election of officers at the official organization meeting held in Cincinnati on March 30, during the Annual Meeting of the Ohio State Medical Association.

Dr. Paul A. Davis, of Akron, president of the American Academy of General Practice, presented the charter to Dr. Linder, making Ohio the 21st state to become affiliated with the national organization.

Other officers elected are: Dr. E. G. Kyle, Newton Falls, president-elect; Dr. E. A. Burgner, Akron, secretary; Dr. Henry W. Lehrer, Sandusky, treasurer; and the following members of the board of directors: Dr. J. Craig Bowman, Upper Sandusky, Dr. P. B. Wiltberger, Columbus, Dr. E. R. Swepston, Cincinnati, Dr. William J. Sheehan, Cleveland, Dr. Roscoe H. Snyder, Toledo, Dr. Howard R. Mitchell, Columbus.

Objectives and purposes of the Academy as stated in its Constitution and By-laws are the following:

1. To define the functions of the General Physician;
2. To promote and maintain high standards of the general practice of medicine and surgery;
3. To encourage the establishment of Sections of General Physicians in active hospital staffs, including their right to vote and hold office;
4. To encourage and assist young men and women in preparing, qualifying, and establishing themselves in general practice;
5. To protect and preserve the right of the General Physician to engage in medical and surgical procedures for which he is qualified by training and experience;
6. To assist in providing postgraduate study courses for General Physicians and to encourage and assist them in participating in such training;
7. To promote fair and proper relations between hospital management and medical staff; and
8. To advance medical science and private and public health.

Cincinnati Periodical List

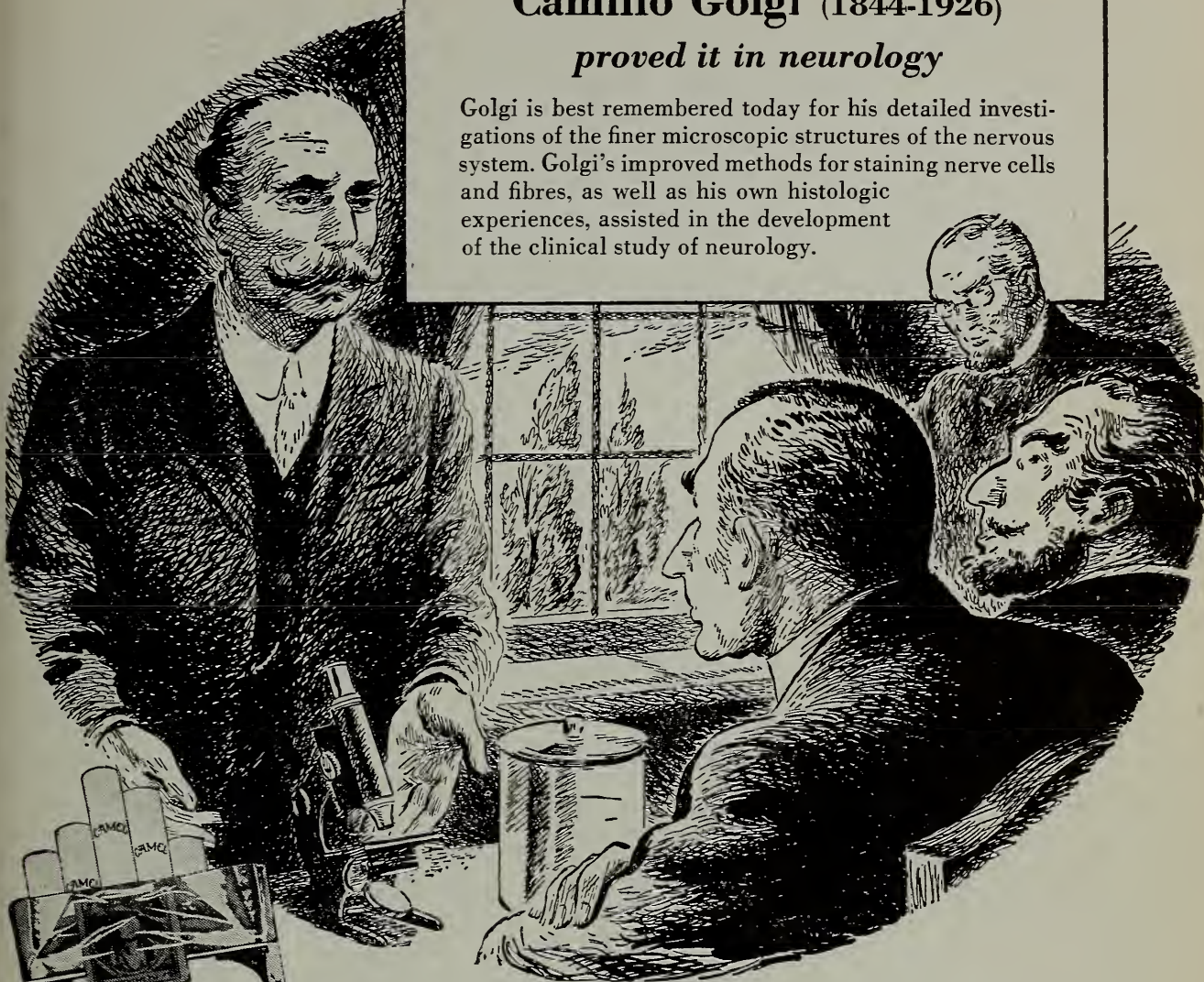
A list of scientific and technical periodicals in the libraries of greater Cincinnati will be published in May. Periodicals on chemistry and medicine are particularly plentiful in Cincinnati, according to the announcement. The list will consist of 125 double column pages, lithoprinted and bound in durable paper. Orders (sold at cost, \$2.50 postpaid) may be addressed to Dr. R. E. Oesper, Department of Chemistry, University of Cincinnati, Cincinnati 21.

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More Doctors Smoke CAMELS than any other cigarette

Three leading independent research organizations in a nationwide survey asked 113,597 doctors what cigarette they smoked. The brand named most was Camel!

Total of 2,387 Registered at Annual Meeting; Other Statistics and Names of Members Attending

TABULATION of registration shows that 2,387 persons attended the 1948 Annual Meeting of the Ohio State Medical Association, March 30, 31, and April 1, in Cincinnati.

A breakdown of registration figures shows that 1,362 members were present. Other classifications are as follows: Out-of-state physicians, 43; interns, residents, and guest physicians, 250; medical students, 27; exhibitors, 214; members of the Woman's Auxiliary, 326; miscellaneous guests, 165.

Following are registration figures for the Annual Meetings held from 1919 through 1948; registration by counties for the 1948 meeting with county membership data; and the names of members of the Association who registered.

Annual Meeting Registration For 1919-1948, Inclusive

Year	Place	Members	Out-of-State Physicians	Guests	Technical Exhibitors	Total
1919	Columbus	1173	10	264	92	1529
1920	Toledo	810	17	105	80	1062
1921	Columbus	1275	28	204	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705
1928	Cincinnati	916	27	92	80	1116
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539
1935	Cincinnati	973	17	197	84	1271
1936	Cleveland	1099	14	563	137	1813
1937	Dayton	1103	18	366	64	1551
1938	Columbus	1330	15	619	104	2068
1939	Toledo	1056	15	271	84	1426
1940	Cincinnati	1126	26	323	114	1589
1941	Cleveland	Joint Meeting with A.M.A.				
1942	Columbus	1221	13	527	119	1880
1943	Columbus	544	13	160		717
1944	Columbus	830	20	441	130	1421
1945	No Meeting					
1946	Columbus	1262	23	679	157	2121
1947	Cleveland	1502	23	561	328	2414
1948	Cincinnati	1362	43	768	214	2387

Registration, 1948 Annual Meeting by Counties And Membership Data

County	Total Membership		Annual Meeting	
	Dec. 31, 1947	March 31, 1948	Registration	
Adams	10	8	4	
Allen	88	87	24	
Ashland	25	25	1	
Ashtabula	52	48		
Athens	36	30	2	
Auglaize	19	17	4	
Belmont	54	50	7	
Brown	5	7	1	
Butler	113	120	43	
Carroll	8	8	4	
Champaign	20	19	6	
Clark	91	93	22	
Clermont	28	25	11	

County	Total Membership		Annual Meeting Registration
	Dec. 31, 1947	March 31, 1948	
Clinton	18	18	7
Columbiana	64	63	7
Coshocton	21	22	4
Crawford	29	29	4
Cuyahoga	1509	1467	95
Darke	23	22	6
Defiance	17	15	4
Delaware	21	18	3
Erie	42	40	5
Fairfield	40	41	8
Fayette	15	13	6
Franklin	645	593	110
Fulton	18	17	4
Gallia	19	19	2
Geauga	12	11	1
Greene	33	31	11
Guernsey	26	28	3
Hamilton	923	886	439
Hancock	40	38	7
Hardin	22	25	4
Harrison	12	12	1
Henry	10	11	1
Highland	25	24	10
Hocking	11	11	3
Holmes	10	9	4
Huron	26	24	4
Jackson	9	11	3
Jefferson	57	57	10
Knox	28	31	2
Lake	36	34	1
Lawrence	23	22	4
Licking	54	55	12
Logan	22	23	3
Lorain	124	121	9
Lucas	416	405	48
Madison	16	13	2
Mahoning	217	230	21
Marion	49	44	6
Medina	29	28	3
Meigs	14	10	3
Mercer	17	18	3
Miami	46	45	17
Monroe	5	4	
Montgomery	373	361	118
Morgan	6	6	4
Morrow	9	9	3
Muskingum	47	47	12
Noble	3	3	
Ottawa	16	17	6
Paulding	11	12	
Perry	12	12	1
Pickaway	18	16	5
Pike	7	9	3
Portage	30	32	4
Preble	13	13	3
Putnam	19	19	4
Richland	83	92	21
Ross	42	43	13
Sandusky	43	46	2
Scioto	64	63	14
Seneca	35	40	5
Shelby	19	18	2
Stark	244	234	41
Summit	337	333	22
Trumbull	91	91	8
Tuscarawas	53	51	10
Union	13	11	6
Van Wert	24	24	5
Vinton	2	2	1
Warren	17	17	4
Washington	32	30	5
Wayne	40	38	2
Williams	16	16	2
Wood	32	28	4
Wyandot	13	11	3
Totals	7106	6919	1362

Members of State Association Registered at 1948 Meeting

Adams County—R. B. Ellison, S. J. Ellison, Hazel L. Sproull, R. C. Wenrick. Allen County—Margaret E. Belt, Fred P. Berlin, Homer G. Deerkake, R. D. Doughty, F. Miles Flickinger, K. G.



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Hawver, V. H. Hay, Fredk. A. Hemsath, Alan D. Knisely, Chas. H. Leech, Harold A. Lotzoff, W. B. Ludwig, Vernon A. Noble, Walter A. Noble, Salvatore Novello, Karl F. Ritter, Franklin Rodabaugh, Martin M. Sondheimer, David L. Steiner, Paul J. Stueber, John E. Talbott, H. A. Thomas, J. R. Tillotson, Carl H. Zinsmeister. Ashland County—A. D. Robertson. Athens County—R. E. Main, David Yospur.

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Pike County—Robert M. Andre, C. L. Critchfield, W. L. McCaleb. **Portage County**—E. M. Kauffman, Elizabeth A. Leggett, Edward T. Meacham, Theo. E. Tetreault. **Preble County**—C. J. Brian, C. E. McKinley, E. P. Trittschuh. **Putnam County**—Dwight L. Becker, H. A. Neiswander, W. B. Recker, Milo B. Rice. **Richland County**—P. M. A. Bein, C. H. Bell, Paul A. Blackstone, L. D. Bonar, Carl R. Damron, Edward D. Dowds, Joseph B. Edelstein, Charles L. Hannum, J. S. Hattery, Harlin G. Knierim, Ernest B. Mainzer, Lizbeth S. Mainzer, Earl C. Mast, Esther M. Mast, John F. McHugh, H. F. Plaut, Myron S. Reed, Robert P. Scott, Charles L. Shafer, F. M. Wadsworth, Robert W. Wolford.

Ross County—Edwin H. Artman, R. C. Bane, Geo. W. Cooper, Harold Crumley, John W. Franklin, L. T. Franklin, Nicholas H. Holmes, Ralph W. Holmes, Charles N. Hoyt, R. E. Lightner, A. E. Merkle, E. Paul Shepard, G. Howard Wood. **Sandusky County**—C. L. Fox, Anthony C. Rini. **Scioto County**—Lorenzo Dow Allard, Sol Asch, Geo. D. Blume, L. B. Hatch, A. P. Hunt, Milton Levine, Elizabeth Long, J. P. McAfee, T. G. McCormick, O. R. Micklethwait, Gilbert Micklethwaite, Wm. A. Quinn, Harry F. Rapp, Chas. S. Vinson. **Seneca County**—G. H. W. Bruggemann, W. R. Funderburg, R. F. Machamer, D. J. Mariea, R. E. Schriner.

Shelby County—H. Eugene Crimm, Russell L. Wiessinger. **Stark County**—L. E. Anderson, J. E. Aten, James Bahrenburg, A. R. Basinger, Hiram John Bazzoli, Harry W. Beck, H. H. Bowman, E. Joel Davis, George A. deStefano, William E. Elliott, Verl Z. Garster, Max Haas, J. Mace Harkey, Mark G. Herbst, Edward A. Hill, Homer I. Keck, Douglass S. King, George L. King, Jr., Robert G. King, J. B. Klein, Chas. A. LaMont, Loyal E. Leavenworth, Otto L. Plaut, George D. Popoff, J. Edwin Purdy, Herbert P. Ramsayer, R. K. Ramsayer, R. L. Rutledge, C. J. Schirack, Gus Shaheen, W. J. Slasor, L. M. Snively, John M. Thomas, G. Otho Thompson, R. E. Tschantz, Graydon D. Underwood, John M. Van Dyke, W. W. Warren, G. M. Wilcoxon, Wm. B. Wild, Pauline Zinninger.

Summit County—Robert T. Allison, Jr., C. R. Anderson, E. W. Burgner, P. A. Davis, P. C. Doran, Harry R. Groppe, Harvey A. Karam, W. P. Kilway, R. M. Lemmon, C. T. McCormish, M. M. Miller, John E. Monnig, Frank T. Moore, C. C. Nohe, Frank A. Oldenburg, R. E. Pinkerton, Edwin A. Riemenschneider, Edward L. Voke, Kurt Weidenthal, Alven M. Weil, L. M. Weinberger, L. A. Witzeman. **Trumbull County**—E. G. Caskey, R. B. Dobbins, J. W. Kohn, E. G. Kyle,

F. LaCamera, S. J. Shapiro, Harry A. Smith, A. L. Sparks.

Tuscarawas County—James S. Adler, Mary Elizabeth Rowland-Aplin, W. W. H. Curtiss, C. M. Dougherty, D. H. Downey, M. W. Everhard, William E. Hudson, M. William Johnson, C. J. Miller, Harold F. Wherley. **Union County**—Fred C. Callaway, Bernard E. Ingmire, A. M. Johnston, P. D. Longbrake, E. J. Marsh, James M. Snider. **Van Wert County**—S. A. Edwards, Roland H. Good, James R. Jarvis, John E. Scheidt, Roy E. Shell. **Vinton County**—H. D. Chamberlain. **Warren County**—R. M. Brewer, O. Williard Hoffman, Orville L. Layman, Leonard Mounts.

Washington County—Clarence E. Ash, Ford E. Eddy, G. E. Huston, M. S. Muskat, W. D. Turner. **Wayne County**—John B. Beeson, F. C. Ganyard. **Williams County**—H. R. Mayberry, Paul G. Meckstroth. **Wood County**—H. W. Mannhardt, Paul F. Orr, Frederick F. Price, R. N. Whitehead. **Wyandot County**—J. Craig Bowman, R. J. Semons, F. M. Smith.

Prominent Guests Join in Honor Of Two 50-Year Doctors

A dinner honoring Dr. R. H. Wilson, Martins Ferry, and Dr. D. O. Sheppard, Barnesville, both of whom have passed the fifty-year mark in their practices, was given on Thursday evening, April 15, at the Belmont Hills Country Club, St. Clairsville, by the Belmont County Medical Society and the Woman's Auxiliary of that society. About 80 persons attended the celebration.

Following the dinner, Dr. Wilson and Dr. Sheppard were presented with gifts on behalf of the two organizations. The presentation address was made by Dr. Louis L. Liggitt, St. Clairsville.

Others who spoke on the after-dinner program were: Dr. A. A. Brindley, Toledo, president, Dr. Carl A. Lincke, Carrollton, president-elect, and Charles S. Nelson, Columbus, executive secretary, of the Ohio State Medical Association; Mr. Howard Sedgwick, Washington, D.C., former resident of Belmont County, who is secretary to Congressman Holmes, State of Washington; and Mrs. C. W. Kirkland, Bellaire, president-elect of the Woman's Auxiliary, Ohio State Medical Association.

Dr. Wilson responded for himself and Dr. Sheppard, thanking the societies for the tribute paid to them and relating some of his experiences during his half-century of practice. Dr. L. D. Covert, Bellaire, served as toastmaster.

The dinner followed a regular meeting of the Belmont County Medical Society. The program consisted of the showing of a motion picture, "Problem Child"; an address by Dr. Brindley on "Choice of Analgesia and Anesthesia in Obstetrics"; a discussion of the paper by Dr. D. E. Greeneltch, Wheeling, West Va.; and a report on the recent Annual Meeting of the State Association in Cincinnati by Dr. Covert, who was an official delegate.

to help vanquish depression marked by "morning tiredness"

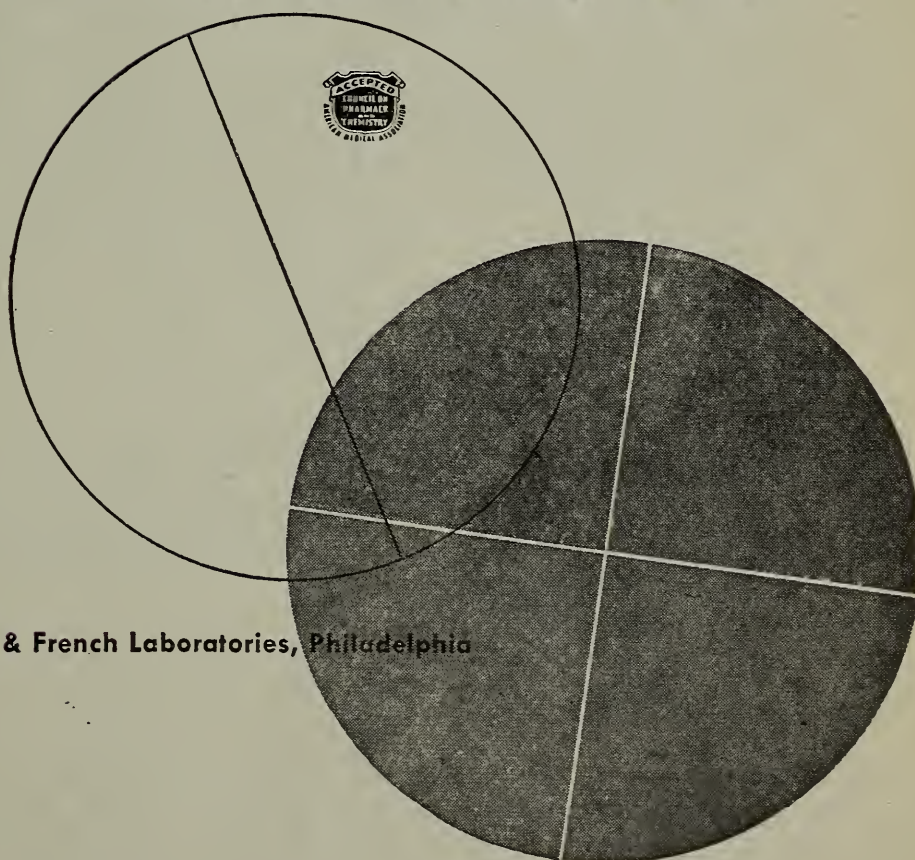
Many depressions are marked by morning tiredness, inertia, lassitude and retardation. 'Benzedrine' Sulfate, taken on awakening, frequently helps to lift the patient "over the hump" of the early hours.

Benzedrine Sulfate—where it shortens, eases, or even eliminates the patient's struggle with depression—may improve the tone of his entire day. While not always effective, Benzedrine Sulfate therapy certainly merits a fair clinical trial in depression marked by morning tiredness.

Tablets Capsules Elixir

Benzedrine* Sulfate

One of the fundamental drugs in medicine



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®T.M., REG. U.S. PAT. OFF. FOR RACEMIC AMPHETAMINE SULFATE, S.K.F.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

VOLUNTARY PLANS MAKING REAL PROGRESS

Blue Cross and Blue Shield, voluntary prepaid hospital and medical care plans, respectively, are continuing to make rapid progress, according to a recent *News Letter* of the Council on Medical Service of the A.M.A. Following are some interesting statistics from the latest survey:

Ninety-one Blue Cross hospitalization plans now have a total of 29,498,527 persons covered, having gained 3,772,000 during the past year.

Ninety medical care plans in operation in 42 states now have a total of approximately 7,500,000 covered, representing a 50 per cent growth during 1947.

The extent to which the American public is covered by voluntary plans of one kind or another against the hazards of disability, or hospitalization, or medical-surgical care is shown by these figures: About 30,000,000 persons are protected against loss of income due to disability; about 40,000,000 covered for hospitalization costs; about 17,000,000 for surgical costs; and about 6,000,000 for medical costs.

Ohio can be proud of the fact that Ohio Medical Indemnity, Inc., sponsored by the Ohio State Medical Association, now ranks sixth in the nation among the voluntary prepayment medical and surgical care plans promoted by the medical profession and ranked fifth in the country in 1947 in average percentage enrollment increase—namely 310 per cent.

These data may be added to the evidence which is building up to show that voluntary programs, in contrast to governmental, compulsory plans, are the answer to the public's demand for protection against the costs of illness on a prepayment basis.

However, now is no time for complacency. The surface has just been scratched. A boost here and boost there by the individual physician in talking with his patients will be a welcomed shot in the arm for all plans.

RESPONSIBILITY OF PHYSICIANS AND THEIR EMPLOYERS

In a recently reported court case in which an employer was sued for negligence for the failure of a member of the medical staff employed by him to make a proper examination and diagnosis of an employee's injuries, the United States Fifth Circuit Court of Appeals rendered an opinion which should be of considerable interest to physicians and employers.

The court pointed out that physicians in under-

taking the duties of their profession impliedly warrant that they are possessed of the requisite skill, learning, and technical training to do the work required of them; the personal liability of the doctor must not be confused with that of his employer; the doctor's liability remains the same whether or not his employer also is liable; the principal is responsible for the tort of his agent; there is no more reason to except employers of physicians from the doctrine of respondeat superior than there is to except employers of other highly skilled persons who perform technical services requiring discretion.

The opinion states that whether the doctor was acting for anyone other than himself when he committed the tort, and if so for whom, is a question of fact.

In other words, as this court has indicated, the physician acting as someone else's agent still is responsible for his own professional acts; the employer who employs physicians to act for him may become equally liable for the negligence of the physician.

N. P. C. SPANKED BY NEWSPAPER JOURNAL

At the recent Cincinnati Annual Meeting, the House of Delegates on recommendation of the Resolutions Committee again refused to put the Ohio State Medical Association on record as endorsing the National Physicians Committee. It reaffirmed the previous policy stating that it is up to each individual physician to decide whether or not he desires to support the N. P. C.

In our opinion, the House of Delegates acted wisely. Evidence is piling up to support the views of many studious physicians that some of the tactics of the National Physicians Committee have been unwise and downright detrimental to the public relations of the medical profession.

The latest bit of evidence supporting this charge is the following editorial published in the March 6, 1948, issue of *Editor and Publisher*, the important trade journal of the newspaper profession, in which the N. P. C. published an advertisement about the "cartoon contest" referred to in the editorial:

QUESTIONABLE CONTEST

"The National Physicians Committee for the Extension of Medical Service, an organization opposed to the Murray-Wagner-Dingell Bill, and other like measures, is offering \$3,000 in prizes to newspaper and magazine cartoonists for their portrayal of the meaning and implications of

For surface infections . . .



New and Nonofficial Remedies . 1947 . states: "NITROFURAZONE.—Furacin... possessing bacteriostatic and bactericidal properties . . . effective in vitro and in vivo against a variety of gram negative and gram positive bacteria . . . is useful for topical application in the prophylaxis and treatment of superficial mixed infections common to contaminated wounds, burns, ulceration and certain diseases of the skin . . . Variant bacterial strains showing induced resistance to sulfathiazole, penicillin or streptomycin are as susceptible to nitrofurazone as their parent strains . . ." Furacin N.N.R. is available in the form of Furacin Soluble Dressing containing 0.2 per cent Furacin. This preparation is indicated for topical application in the prophylaxis and treatment of infections of wounds, second and third degree burns, cutaneous ulcers, pyoderma and skin grafts. Literature on request. EATON LABORATORIES, INC., NORWICH, N. Y., — TORONTO, CANADA

"political distribution of health care services in the United States." An ad announcing this 'contest' with \$1,000 first prize appeared in *Editor & Publisher* last week.

"Completely ignoring the political viewpoint of this Committee, which it is not our function to criticize or evaluate, let us analyze the 'contest.'

"First, the rules make it clear that no cartoon will qualify for one of the 14 cash awards unless it takes a position against the proposed bill. A 'Ding' Darling cartoon, printed in the ad lambasting 'Socialized Medicine,' serves as a guide.

"Secondly, proof of publication is required to enter the 'contest.'

"The 'contest' rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs (according to how you look at it) and to obtain general circulation for those beliefs in newspapers and magazines. In other words, large cash rewards are offered to cartoonists for doing a propaganda job in behalf of the physicians' committee.

"We classify this 'contest' with those photography contests which require cameramen to portray certain products in their published photos—cigars, coffee, etc.—in order to qualify for an award. They are all a threat to independent thinking, objective and unbiased reporting and comment in newspapers.

"They offer rewards for doing a slanted job in newspapers and magazines. And it will be difficult for any cartoonist or his editor to deny the charges of critics that they were bribed by the \$1,000 first prize into supporting the viewpoint of the Physicians Committee, even though their opinion may have been arrived at independently.

"The American Society of Newspaper Editors, and all editors' groups, should take a firm stand against such 'contests.' The Canons of Journalism should be amended to require that all newspapermen ignore the cash rewards offered in so-called 'contests' in which qualification is based on getting mention of a product or one side of a controversial political subject into the paper."

GOOD JOB DONE WITHOUT SUPER-DUPER DIRECTION

During the past five years, the State of Ohio had to import out-of-state and foreign laborers in rather substantial numbers to help on Ohio farms. Certain services, including medical and hospital care, had to be provided for the imported workers. Federal funds were made available for these services.

When the program was set up, some Federal officials, as usual, wanted to set up a super-duper regional administrative agency to handle the administrative details of the medical and hospital care features of the program. Such an agency for Midwestern states was set up. Ohio did not participate because the Farm Labor Office of the Agricultural Extension Service, Ohio State University, after consultation with the Ohio State Medical Association, the Ohio Hospital Association, and Ohio Department of Health, decided that it could handle this work

and that an outside super-administrative agency was not needed.

This particular farm labor program ended with the close of 1947. A report for 1946 shows that about \$25,000 was paid out in that year for medical and hospital services; about \$21,000 in 1947. It points out that the program was administered with a minimum amount of expense and trouble because of the cooperation of the three state organizations named above, their local units, and their members.

All of which again proves that programs of these types can be handled adequately by state agencies and local community groups; that administration on a regional or Federal basis is unnecessary.

In our opinion, the medical profession of Ohio owes a vote of thanks to those in the Agricultural Extension Department, Ohio State University, who stood for the policy of local administration and who did such a fine job of running the program.

WELL-DESERVED TRIBUTE PAID TO DR. HOUSER

In voting a special tribute to Dr. D. C. Houser, Urbana, the House of Delegates during the recent meeting in Cincinnati, honored a gentleman, scholar, and fine physician—a man who has made innumerable contributions to the medical profession, to the people of his community, and to the Ohio State Medical Association, during his 51 years of active practice and during the 46 years that he has served continuously in the House of Delegates of the Association.

While serving as a delegate, as an officer, or a committeeman of the Ohio State Medical Association, Dr. Houser never failed to keep himself in tune with the times and with the thinking of the younger generation of physicians. His career as a medical statesman sets an example which those who are now in the harness, or who will become leaders in the future, would do well to follow.

EDITOR ROCKWELL OFFERS SOME GOOD ADVICE

Although pointing out that there is a real shortage of physicians in many outlying areas of Ohio and disagreeing with *The Journal of the A.M.A.* for having intimated that the shortage is more imaginary than real, C. K. Rockwell, editor of the *Wapakoneta Daily News*, takes a very sensible point of view on the whole question of supply and demand of medical personnel in a recent editorial in that newspaper.

Wrote Mr. Rockwell:

"However, *The Journal* gives us something to think about when it points out that medical schools are taking the maximum number of

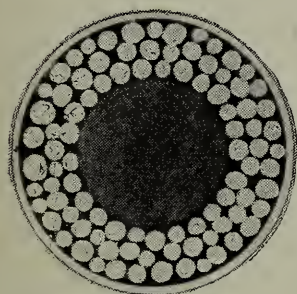
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The coating of Barlow-Maney Tablets Aminophylline Enteric Coated is described in New and Nonofficial Remedies, 1946.



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Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.

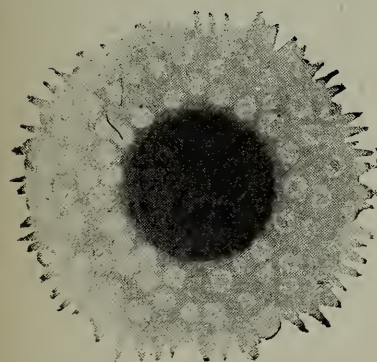
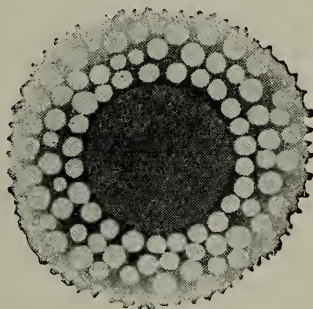


Fig. 3 — Complete disintegration.

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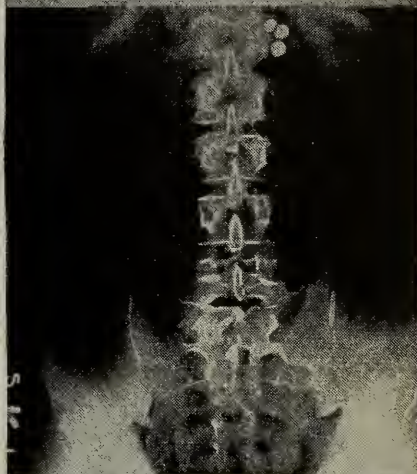
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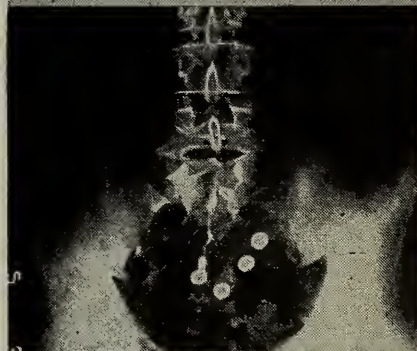
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CLINICAL CONFIRMATION



Radiograph taken five minutes after intake of 6 tablets Enteric Coated B-M . . . all tablets are in stomach.



Four hours later . . . all tablets now in intestines.



Six hours later . . . all tablets disintegrated or in that process.

students possible at the present time. There is no point in hurrying students through premed if there is no place for them in medical schools; nor do we want the latter to lower their standards to take on more students than they can properly instruct.

"The only real solution to the problem is, of course, to enlarge and increase the medical schools. This will cost money but it will save more—as well as prevent much suffering and unnecessary deaths.

"We doubt if doctors have any desire to keep down the number of graduates from medical schools; most good doctors would welcome relief from the burden of overwork they are now carrying. They naturally are opposed to any lowering of the standards of the profession as a means of providing more doctors in a shorter time. An incompetent doctor is worse than no doctor."

Unlike others, Mr. Rockwell does not blame the medical profession for the shortage and unlike others he does not advocate turning out a lot of half-baked physicians to solve the problem.

WHAT IS THE PRICE OF A PRACTICE?

During this period of readjustment and relocation, some physicians are endeavoring to dispose of their practices and others want to take over established practices of those wishing to retire or to relocate.

Obviously the question arises: What is the selling (or buying) price of a practice?

A very helpful memorandum on this question was prepared recently by Dr. Frank G. Dickinson, director, Bureau of Medical Economic Research, American Medical Association.

The Columbus Office of the Ohio State Medical Association has a limited number of copies of the memo. It will gladly send one to any member who may request a copy.

WHEN, OH WHEN, ARE WE GOING TO WAKE UP?

Commenting on the survey of Governors on pending Federal health legislation, made by U.S. Senator Smith of New Jersey, one of our esteemed contemporaries observed:

"There seems to be a growing antipathy among the state executives toward any proposal to promote the intervention of the Federal Government in functions and responsibilities heretofore reserved to and by the states."

Maybe so, but too many of the chief executives when they hear the jingle of Federal money, seem to forget all about the so-called Federal intervention. The same goes for too many state legislative bodies.

Unfortunately, this situation has prevailed in Ohio. Unfortunately, too many business groups have failed to see the woods because of the

trees. They protest additional Federal taxes—with justification—but at the same time they oppose state legislation which would provide adequate finances for Ohio's health activities, making it necessary for Ohio agencies to depend largely on Federal aid for their work.

One Ohio state-wide business group has figured out that the pending Truman budget would cost each man, woman, and child in Ohio about \$296 in taxes. A lot of that money, if collected, would be returned to Ohio in the form of grants-in-aid, or what-have-you. But the sad part of it is that each dollar would have a big nick in it, representing Federal administrative overhead. Wouldn't it be far cheaper for Ohio to foot its own bills? While doing it, it would be running its own show—not letting some Federal agency run it.

When are we going to wake up?

HOW ABOUT A CHIT-CHAT WITH YOUR MINISTER?

Commenting on some of the actions taken at the recent Ohio Pastors' Convention in Columbus on legislative matters affecting business, the bulletin of one of the state organizations representing a retail business group observed:

"We believe it is time businessmen, besides financially supporting the church, also enlighten their minister on the problems of operating a business today."

Judging from some of the public statements which have been made recently by some churchmen regarding medical and health questions, many of which indicated a lack of accurate information on such matters, physicians also should do a bit of missionary work among the clergy.

The pulpit can be a potent medium for the dissemination of facts or propaganda, depending on the belief of the minister and on how well informed he happens to be.

A GOOD PROPOSITION TO PASS UP

We understand that Ohio physicians have been receiving postal cards offering them a "proposition" to do refractions, signed by one Bennett Shirwo, 111 W. Jackson Blvd., Chicago.

Reliable sources reveal that Shirwo is in the business of selling lenses and frames. He sends persons wanting glasses to optometrists and physicians who sign up with him. Of course, the deal is that he will fill all the prescriptions.

Not that we believe any ethical Ohio physician would fall for this gag, but just to keep the record straight, we felt obligated to pass along the information as to how the game is played.



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Official of A.M.A. Testifies on Two Important Bills Before Congress; One Is Opposed, the Other Endorsed

URING the past month testimony on two bills pending in the Congress was offered on behalf of the American Medical Association by Dr. James R. Miller, Hartford, Conn., member of the Board of Trustees. One measure, S. 1290, the so-called school health bill, is before the Senate Committee on Labor and Public Welfare; the other, H.R. 5644, to provide Federal grants to states for local public health department activities, is pending in the House Committee on Interstate and Foreign Commerce.

Regarding S. 1290, Dr. Miller stated that the A.M.A. "must regretfully withhold approval" until some of the uncertainties in the bill are clarified and "until there is presented convincing argument that it is socially desirable that government should segregate a segment of the population (30,000,000 children) and provide for it one of the necessities of life, (medical care) to the exclusion of other necessities, and without consideration being given to the ability or inability of any member of that segment to take care of his own needs or to have those needs supplied by those lawfully obligated to do so."

ARGUMENTS AGAINST S. 1290

Other arguments he made in opposition to the proposal were, that it would:

1. Authorize "demonstrations," the exact nature of which is not disclosed.
2. Provide for the training and supervising of school personnel "in utilizing the findings of health examinations"; but there is no indication in the bill as to the manner in which such findings are to be utilized.
3. Exclude the providing of health instruction under a state plan "other than that given as a part of examination, diagnostic or corrective procedures," apparently separating, with the exceptions noted, the areas of health services and health instruction, both vital and inseparable parts of the total school health program.
4. Assume that there are a considerable number of school children in need of medical services which need is not met solely because of lack of ability to purchase the services.
5. Assume that the states are unable to finance a school health program without the aid of Federal financial assistance.
6. Not contemplate an integrated approach to a well-rounded school health program; as it does not take into consideration physical conditions that may be detrimental to school health such as poor sanitation of the school, inadequate ventilation and lighting, overcrowding of rooms, and contaminated water supplies, among other conditions.
7. Establish an entirely new policy by projecting the schools into the field of curative medicine so far as school children are considered, a projection that has been disapproved either explicitly or by implication by various educational groups.

8. Bring a third agency, the Children's Bureau, at the Federal level, into the school health program which is already complicated by being shared by the education authorities and the public health authorities.

9. Not guarantee any freedom of choice on the part of the child, or by anyone acting for him, of the physician, dentist, or other personnel who is to render the service proposed by the bill.

10. Authorize the supplying of school health services to children whose parents are amply able to pay for the services that are considered to be needed.

AID TO HEALTH UNITS ENDORSED

Pointing out that the American Medical Association has consistently sought to extend public health coverage and has endorsed Federal aid to assist in the development of local health units, Dr. Miller stated that the A.M.A. approved H.R. 5644 in principle.

However, he offered a number of suggested amendments to make the legislation more effective, as follows:

Section 3 defines a "local public health unit" as a governmental authority of a local area authorized to provide in such area "basic public health services," but there is no definition contained in the legislation as to what shall constitute "basic public health services." Section 5 authorizes the Surgeon General of the Public Health Service by regulation to prescribe the "types of health services" which shall be considered basic public health services.

It is the A.M.A. viewpoint that the law itself should state what shall constitute "basic public health services" and, as a corollary, that such determination should not be left to any Federal administrative officer.

Section 3 of the pending bill should be amended by adding a definition of basic public health services to include the following functions and to exclude "the care of the sick" as a function except where that care is necessary for the protection of the health of the community:

BASIC SERVICES

1. Vital statistics, or the recording, tabulation, interpretation, and publication of the essential facts of births, deaths, and reportable diseases;
2. Control of communicable disease, including tuberculosis, the venereal diseases, malaria, and hookworm disease;
3. Environmental sanitation, including supervision of milk and milk products, food processing and public eating places, and maintenance of sanitary conditions of employment;
4. Public health laboratory services;
5. Hygiene of maternity, infancy, and child-

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A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology; embryology; physiology; neuro-anatomy; anesthesia; physical

therapy; allergy; examination of patients pre-operatively and follow-up post-operatively in the wards and clinics.

For the GENERAL PRACTITIONER

Intensive full time instruction in those subjects which are of particular interest to the physician in general practice, consisting of clinics, lectures and demonstrations in the following departments—medicine, pediatrics, cardiology, arthritis, chest diseases, gastroenterology, diabetes, allergy, dermatology, neurology, minor surgery, clinical gynecology, proctology, peripheral vascular diseases, fractures, urology, otolaryngology, pathology, radiology. The class is expected to attend departmental and general conferences.

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A three months full time course covering general and regional anesthesia, with special demonstrations in the clinics and on the cadaver of caudal, spinal, field blocks, etc.; instruction in intravenous anesthesia, oxygen therapy, resuscitation, aspiration bronchoscopy.

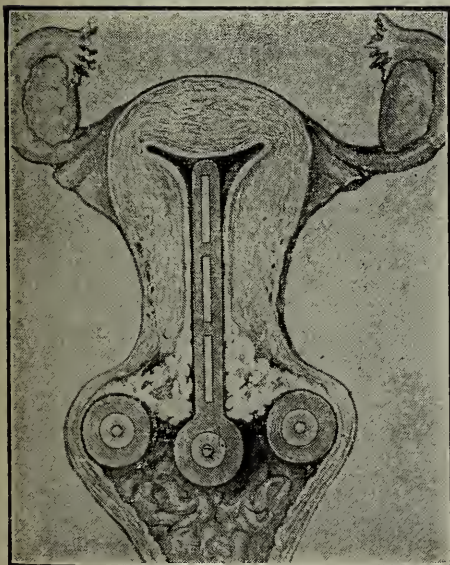
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hood, including supervision of the health of the school child;

6. Health education of the general public so far as not covered by the functions of departments of education.

As now drafted the bill confers on the Surgeon General the right to withhold approval of a state plan and to withdraw approval of a state plan if in his opinion it does not conform to certain specifications. The desirability of assuring an appeal by a state whose plan has been disapproved, either to a public health advisory council, which the legislation should establish to guide the administration of the law, or to the courts, or to both, was suggested by Dr. Miller.

Also he suggested the desirability of stating as a part of the Declaration of Policy and Purpose that it is the intent of the Congress in enacting this legislation to preserve to the states and to their local units the directing control of the operation of any public health units to be provided under a state plan and that authorized regulations must be promulgated with that objective in view.

"This is most important legislation and in my judgment it will function more effectively with the least amount of interference and direction by government," he declared.

COMING MEETINGS

American Medical Association Annual Meeting, Chicago, June 21-25.

American Association for the Study of Goiter, Toronto, Canada, May 6-8.

American Urological Association, Boston, May 17-20.

American Association of Genito-Urinary Surgeons, Skytop, Pa., May 12-14.

American Association of the History of Medicine, Philadelphia, Pa., May 26-27.

American Association on Mental Deficiency, Boston, Mass., May 12-15.

American Hearing Society, Pittsburgh, Pa., May 19-23.

American Ophthalmological Society, Hot Springs, Va., May 16-19.

American Pediatric Society, Quebec, Canada, May 24-26.

American Physiotherapy Association, Chicago, Ill., May 23-28.

American Psychiatric Association, Washington, D. C., May 17-20.

International Congresses on Tropical Medicine and Malaria, Washington, D. C., May 10-18.

West Virginia State Medical Association 81st Annual Meeting, Huntington, W. Va., May 10-12.

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In Memoriam

I. Newton Agenbroad, M.D., Celina; Eclectic Medical College, Cincinnati, 1891; aged 84; died April 1. Surviving are a daughter, three sisters and a brother.

Louis Charles Benkert, M.D., Columbus; Ohio Medical University, Columbus, 1897; aged 74; died April 4; former member of the Ohio State Medical Association and the American Medical Association through 1946. Dr. Benkert formerly was Franklin County Coroner and practiced medicine for 50 years in Columbus. For many years he was proprietor of a pharmacy in that city. He was a member of several Masonic orders, the Northside Commercial Club, the Order of Eagles, and was past-president of the Buckeye Fishing Club. He is survived by a sister.

Ellsworth Francis Brandon, M.D., Edon; Michigan College of Medicine and Surgery, Detroit, 1900; aged 73; died March 19 in Blythe, Calif.; former member of the Ohio State Medical Association and the American Medical Association in 1927. Dr. Brandon practiced medicine in Edon for 48 years. He is survived by his widow and two daughters.

James E. Campbell, M.D., Columbus; Starling Medical College, Columbus, 1897; aged 71; died March 30; he is survived by his widow, two sons, three brothers and a sister.

Clara Hyde Gillard, M.D., Port Clinton; The Hahnemann Medical College and Hospital, Chicago, 1889; aged 86; died April 8; former member of the Ohio State Medical Association and the American Medical Association in 1928. Dr. Gillard, widow of the late Dr. David Gillard, practiced medicine for many years in Port Clinton, but retired upon the death of her husband.

Edward H. Hake, M.D., Youngstown; Dunham Medical College, Chicago, 1902; aged 75; died March 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Hake practiced medicine in Youngstown for approximately 40 years. He is survived by his widow, four daughters, a son and a brother.

Enoch N. Heston, M.D., Columbus; Columbus Medical College, 1896; aged 78; died March 27. Dr. Heston was retired from active practice at the time of his death. He was a member of the Presbyterian Church and several Masonic orders. He is survived by a son, a sister and a brother, Dr. Herman E. Heston, of Columbus.

Errett LeFever, M.D., Glouster; Medical College of Ohio, Cincinnati, 1890; aged 81; died March 19; member of the Ohio State Medical

Association and the American Medical Association, and chairman of the Legislative Committee of the Athens County Medical Society, 1942-44. Dr. LeFever practiced medicine in Glouster and the surrounding area since 1906. In addition to his practice, he served approximately 26 years in the Ohio General Assembly—12 years in the Senate and 14 years in the House. Among committees he served on during his terms of office were Finance, Education, Rules, Insurance, Health, and Mines. He was a member of the Masonic Lodge, and had been presented a 50-year pin in that order. Surviving are a son, Dr. Harry E. LeFever, Columbus, a daughter and a sister.

William Case Manchester, M.D., Alliance; Western Reserve University School of Medicine, 1898; aged 75; died April 8; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Manchester was a practicing physician in Alliance since 1901. He was a member of the Methodist Church, the Rotary Club, and the Wranglers Club. Surviving are his widow, two daughters and two sons, one of whom is Dr. Robert C. Manchester, of Seattle, Wash.

Raymond Dustin Potts, M.D., Dayton; University of Cincinnati College of Medicine, 1918; aged 58; died March 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Potts practiced medicine in Dayton for 30 years. Surviving are his widow, a daughter, two sons, a sister and a brother.

Garrit Walter Raidt, M.D., Norwood and Cincinnati; University of Cincinnati College of Medicine, 1931; aged 42; died March 18; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1946. Dr. Raidt practiced his profession in Norwood and Cincinnati since the completion of his medical education. He was a member of the Presbyterian Church. Surviving are his widow, a daughter and his mother.

Ralph Reece, M.D., Cincinnati; University of Cincinnati College of Medicine, 1946; aged 26; died April 7; Dr. Reece had completed his internship but was prevented from entering practice by illness. He is survived by his parents, a sister and a brother.

Edward John Christian Sander, M.D., Steubenville; Starling Medical College, Columbus, 1902; aged 76; died March 28; a former member of the Ohio State Medical Association and the American Medical Association through 1946, and served on the Legislative Committee of the Jefferson

County Medical Society from 1938 through 1946. Dr. Sander practiced medicine for 45 years in Steubenville. He was at one time Mayor of the city and served also on the City Council. Surviving are two brothers and a sister.

Isaac Everett Treece, M.D., Arlington (Hancock County); Ohio State University College of Medicine, 1937; aged 35; died March 17; member of the Ohio State Medical Association and the American Medical Association, and vice-president of the Hancock County Medical Society in 1941. He was a member of the Masonic Order, the Arlington School Board and Lions Club, and of Alpha Omega Alpha fraternity. Surviving are his widow, a son, his mother, three sisters and five brothers, including Dr. Harold K. Treece, of Arlington.

Wilbur George Weiss, M.D., Cleveland; Ohio State University College of Homeopathic Medicine, 1916; aged 57; died April 6; he is survived by his widow.

Buckeye News Notes

Bellefontaine—Socialized medicine was assailed at a recent meeting of the Bellefontaine Chapter of Symposiarchs by four physicians. They were Drs. Charles L. Barrett, John B. Traul, C. K. Startzman, and Warren F. Mills.

Canton—Dr. Howard Weaver was named president-elect for 1949 at the annual meeting of the Canton Academy of Medicine Jan. 23. Other officers are: Dr. Charles Paradis, re-elected secretary-treasurer; Dr. Pauline Zininger, librarian; Dr. O. G. Wilson and Dr. J. E. Aten, trustees. Dr. Mark G. Herbst assumed office as president for 1948.

Chardon—Dr. H. E. Shafer, Middlefield, was elected president of the Geauga County Health Board at a recent meeting.

Cleveland—William B. Seltzer recently announced his resignation as superintendent of Mt. Sinai Hospital, and said his plans are to get out of the hospital field.

Cleveland—Dr. Victor C. Laughlin was elected chief of staff of Huron Road Hospital.

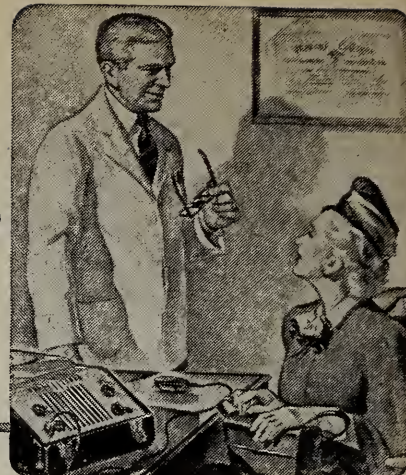
Clyde—Dr. A. C. Rini was guest speaker at a recent meeting of the Clyde Mothers' Club. His subject was "Thyroid."

Columbus—Dr. Jonathan Forman, editor of *The Journal*, and Charles S. Nelson, executive secretary of the Ohio State Medical Association, acted as source experts at a workshop held by the Ohio State Grange on March 23.

Columbus—Dr. Thomas E. Rardin was elected president of the Metropolitan Health Council to succeed Dr. Harve M. Clodfelter.

Columbus—Dr. George T. Harding, III, medical superintendent of the Harding Sanitarium in Worthington, and professor of psychiatry at

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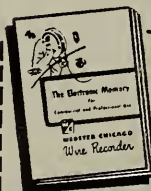
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Ohio State University, also a member of the Board of Examiners in New York City, addressed the Columbus Junior Chamber of Commerce on Feb. 5.

Crestline—Dr. J. A. Agnew was re-elected for another five-year term on the Crawford County District Board of Health.

Eaton—Dr. G. W. Flory, of Eaton, and Dr. J. H. Kinsey, of Richmond, Ind., recently celebrated the 60th anniversary of their graduation from the Physio-Medical College at Indianapolis.

Fremont—Dr. W. J. Martin addressed members of the Hayes Mothers' Study Club at a recent meeting.

Hamilton—Dr. Henry A. Long was reappointed a member of the Hamilton Metropolitan Housing Authority.

Huron—Dr. C. E. Swanbeck addressed a recent meeting of the Huron Rotary Club on the subject of cancer.

Kent—"Facing Old Age" was the topic of a talk by Dr. Harry V. Paryzek, Cleveland, before a January meeting of the Kent Kiwanis Club.

Plain City—Dr. E. S. Holmes was the subject of a feature story in a recent issue of the *Plain City News*. He has been practicing from the same office since 1898.

Port Clinton—Dr. Gordon R. Ley recently addressed the Port Clinton Rotary Club on the subject, "Cancer and Its Effects."

Springfield—Dr. Ray M. Turner spoke at a recent meeting of the Springfield Business and Professional Women's Club on the subject, "Facts and Fallacies of Infection of the Intestinal Tract."

Troy—Dr. Harry E. Shilling was elected president of the Miami County Tuberculosis and Health Association at the annual meeting March 16. Principal speakers at the meeting were Dr. Arnold B. Kurlander, Columbus; Dr. Brent A. Welch Troy; and Dr. Lynne E. Baker, Dayton.

Xenia—Dr. Gordon E. Savage is health commissioner of the new combined Fayette and Greene County health district.

Zanesville—Dr. C. M. Rambo recently was honored with a life membership in the Zanesville Elks Lodge.

Art Exhibit at A.M.A. Meet

Physicians who wish to exhibit at the Chicago Art Exhibition in connection with the Annual Session of the American Medical Association, June 21-25, are advised to write for entry blanks, rules, shipping labels, etc., to Dr. Francis H. Redewill, Secretary, American Physicians Art Association, Flood Building, San Francisco, Calif. Entries must reach Chicago between May 1 and June 12.



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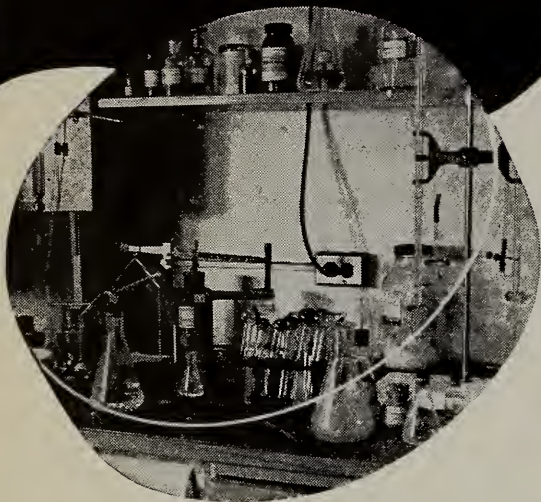
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Do You Know?...

Dr. Charles T. Dolezal, superintendent of City Hospital, Cleveland, will leave that position to become assistant director and secretary of the Council on Professional Practice of the American Hospital Association.

* * *

Recently named associate director of the Rockefeller Foundation's division of medical sciences, Dr. Wade W. Oliver, professor of bacteriology at Long Island College of Medicine, is a former Cincinnatian.

* * *

Dr. Warren Payne, medical director, Ohio Rubber Co., Willoughby, spoke on "Medical Problems in Small Industries," at a joint session of the American Association of Industrial Physicians and Surgeons and the American Association of Industrial Nurses, April 2, at Boston, Mass.

* * *

Another Ohio health district, Tuscarawas County, has employed a full-time health commissioner. He is Dr. Thomas S. McGough, who will receive a degree of master in public health from Johns Hopkins University in May.

* * *

Four physicians still in active practice in Mansfield have a combined 206 years in medicine. They are: Dr. J. L. Stevens, 53 years; Dr. J. M. Garber, 52 years; Dr. Robert R. Black, 51 years; and Dr. J. A. Yoder, 50 years.

* * *

William A. Starin, Ph. D., of the Ohio State University department of bacteriology will retire from active service at the end of this academic year, after 38 years teaching at the university.

* * *

Dr. A. J. Richie, Dr. George Jones, and Dr. James A. Coleman of Toledo, recently held a reunion of the class of 1898 of the Old Toledo Medical College. The other three surviving member of the class, which numbered 34, are Dr. Howard Green, Toledo; Dr. A. M. Wilkins, Delta; and Dr. Charles Peabody, Odessa, Mich.

* * *

The Life Insurance Medical Research Fund sponsored by the life insurance companies of the United States has given a grant-in-aid of \$7,875 to Dr. Johnson McGuire, Cincinnati, for research on cardiac reflexes, myocardial disease and cardiac function at the University of Cincinnati College of Medicine. He will be assisted by Dr. Noble O. Fowler, Jr.

* * *

According to the *Statistical Bulletin* of the Metropolitan Life Insurance Company, the divorce rate in the United States between 1941 and 1946 increased 130 per cent among those

married less than five years, the rate rose 55 per cent among those married 5 to 9 years, and 33 per cent among those married 10 to 14 years.

* * *

In 1945, for the first time in this nation's history, Negro tuberculosis deaths fell below 100 per 100,000 population, to a new rate of 98.0. The comparable rate for white persons is 32.7.

* * *

Dr. Theodore G. Klumpp is the new president of the American Pharmaceutical Manufacturers Association. President of Winthrop-Stearns Inc., Dr. Klumpp formerly was secretary of the Council on Pharmacy and Chemistry of the American Medical Association and chief of the Drug Division of the United States Food and Drug Administration.

* * *

The *Statistical Bulletin* of the Metropolitan Life Insurance Company reports a 40 per cent reduction in mortality from toxic goiter among its industrial policy holders in the period of 1940 to 1947. In 1945 there were 2,408 deaths from toxic goiter in the general population of the United States as compared with 3,659 in 1940.

* * *

The National Institute of Health of the U. S. Public Health Service has established an Experimental Biology and Medicine Institute. The new research institute will combine the functions of the Division of Physiology and the Pathology and Chemistry Laboratories, and is expected to permit greater coordination of scientific investigations.

* * *

"Save a Life", the health education column of the Cincinnati Public Health Federation, has been a daily feature of the *Cincinnati Times Star* for 14 years. The articles are prepared with the cooperation of the local health department, and are supervised by the Academy of Medicine.

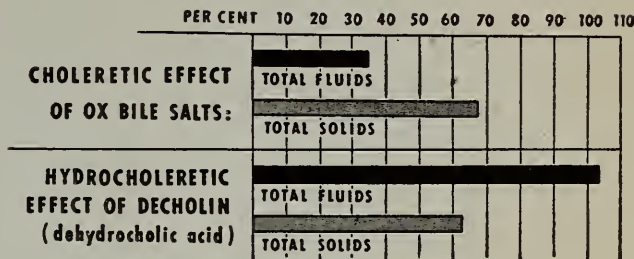
* * *

Three hundred St. Paul and Minneapolis businessmen between the ages of 45 and 54 are serving as test subjects in a ten-year study of high blood pressure. The study, which is being conducted at the University of Minnesota, will attempt to determine whether habits of diet and exercise affect diseases of the heart and blood vessels.

* * *

Robert C. Foreman, a student in Western Reserve University School of Medicine, Cleveland, won second prize of \$300 in the annual contest of The Schering Corporation for the best manuscripts on a designated phase of endocrinology. Medical students of the United States and Canada are eligible for the contest.

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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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With the Veterans Administration

Under date of April 7, Dr. Peter A. Volpe, medical director, Branch No. 6, Veterans Administration, serving Ohio, Michigan, and Kentucky, transmitted the following bulletin to all Regional Offices in the area, requesting an intensified campaign to recruit additional full-time and part-time medical personnel for all V.A. offices:

1. It is requested that an intensive campaign be made to recruit qualified professional employees, both full-time and part-time. It is suggested that contact be made with the local county medical society, through the Veterans Medical Committee where such a committee exists, along with the deans of local medical colleges, for aid in this recruitment campaign. The development of a part-time staff of specialists in the regional offices should be planned with the Dean's Committee so that regional offices might at some future date be used in a residency teaching program.

2. It is also suggested that in the employment of part-time physicians, other than specialists, an endeavor be made to secure the services of the younger group of physicians who are comparatively recent graduates. It is believed that this group, who are in the process of building up their practices, could devote more time to V.A. work than physicians with a well-established practice. Veterans should be given preference.

3. It is desired to emphasize that in utilizing the services of part-time physicians in regional offices it is absolutely essential that a well-organized and efficiently operated appointment system be established.

4. If applications are submitted to offices where the services of the applicants cannot be used, the applications will be forwarded to branch office with a statement that no suitable vacancy exists at these offices.

5. The representatives of the American Medical Association have agreed to inform component state and county medical societies of this program and it is believed that full cooperation will be received from your local society.

Ohio State Alumni Dinner

The Ohio State Medical Alumni will hold a dinner meeting at the Palmer House, Chicago, on Wednesday, June 23, during the Annual Session of the American Medical Association, according to Dr. Morris S. Rosenblum, Youngstown, program chairman. Dr. William M. Skipp, Youngstown, president of the Alumni, will give a cocktail party before dinner which is scheduled for 6 p. m.

"The Physiology of the Gastro-Intestinal Tract" will be the topic for the first Inter-Hospital Postgraduate Training Course to be held at the Academy of Medicine Building, Toledo, May 11-14. There will be three lectures each day, the first from 12 noon to 1 p. m., the second from 4:15 to 4:45 p. m., and the evening sessions from 8 to 9 p. m. Dr. M. I. Grossman, Department of Physiology of the University of Illinois College of Medicine, will be the instructor.

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Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting May 24, June 21, Aug. 2.

Surgical Anatomy & Clinical Surgery, two weeks, starting May 10, June 7, July 6.

Surgery of Colon & Rectum, one week, starting May 24, June 14. Surgical Pathology every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 27.

FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting June 7.

OPHTHALMOLOGY—Intensive Course, two weeks, starting May 10. Ocular Fundus Diseases, one week, starting June 7.

GYNECOLOGY—Intensive Course, two weeks, starting June 7, Sept. 13. Vaginal Approach to Pelvic Surgery, one week, starting June 21.

OBSTETRICS—Intensive Course, two weeks, starting June 21, September 27.

MEDICINE COURSE, two weeks, starting June 7.

Personal Course in Gastroscopy, two weeks, starting June 28, July 12.

Electrocardiography & Heart Disease, two weeks, starting August 2.

Hematology, one week, starting May 10.

Gastroenterology, two weeks, starting May 24.

DERMATOLOGY—Formal Course, two weeks, starting June 7. Clinical Course every two weeks.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

The Second Annual Invitational Meeting of the Butler County Medical Society will be held on Thursday, May 13, in the Manchester Hotel, Middletown. The following program will be presented by the Department of Medicine and Surgery, University of Cincinnati College of Medicine:

4 p. m.—Dr. William Bean, "Cirrhosis of the Liver."

5 p. m.—Dr. B. N. Carter, "The Surgical Treatment of Cirrhosis of the Liver."

8 p. m.—Dr. Leon Schiff, "The Jaundiced Patient."

9 p. m.—Dr. M. M. Zinninger, "Surgery of the Jaundiced Patient."

At 6 p. m. a cocktail party will be given by the Butler County Medical Society, followed by dinner.

CLINTON

Discussion on hospital building plans was held at the March 2 meeting of the Clinton County Medical Society.

HAMILTON

The Academy of Medicine of Cincinnati had as guest speaker for the March 2 meeting Dr. Philip D. McMaster, associate member of the Rockefeller Institute of Research, New York City. His subject was "The Lymphatics of the Skin in Defense of the Body Against Injury and Infection."

Dr. Howard C. Naffzinger, chairman of the Department of Neurological Surgery, University of California Medical School, was principal speaker at the March 16 meeting. His subject was "Our Present Knowledge of Exophthalmos and Its Surgical Treatment."

Dr. Maxwell Finland, Harvard Medical School, was guest speaker at the April 6 meeting of the Academy. His subject was "Some Considerations of the Use of Antibiotics and Chemotherapy."

HIGHLAND

Support of the Highland County Medical Society was pledged at its February meeting toward efforts to improve the health program in the county.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

Five members of the Clark County Medical Society were honored recently by fellow members for 50 or more years of medical practice. They are Drs. R. C. Hebble, Horace L. Heistand, E. F. Davis, Charles W. Evans, and J. A. Link.

DARKE

Speaker at the March 16 meeting of the Darke County Medical Society was Dr. R. E. Pumphrey,

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Dayton, who spoke on the "Importance of the Routine Rectal Examination."

MIAMI

Dr. Kenneth F. Lowry, Troy, presented an illustrated talk on "Delayed Suture in the Management of Wounds" at the March meeting of the Miami County Medical Society.

MONTGOMERY

Dr. Bruce K. Wiseman, Ohio State University College of Medicine, addressed the April 7 meeting of the Montgomery County Medical Society on the subject, "A Modern Approach to the Treatment of Anemia."

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D.,
UPPER SANDUSKY)

MARION

Dr. Warren C. Sawyer discussed the subject, "Rehabilitation and Treatment of Disease and Disorders in Later Life" at the March 10 meeting of the Marion County Academy of Medicine at Hotel Harding, Marion.

SENECA

Two Tiffin physicians, Dr. Robert C. Chamberlain and Dr. William H. Benner, were honored by members of the Seneca County Medical Society March 9 in observance of 50 years of medical practice. Guest speaker was Dr. Maurice A. Schnitker of Toledo, who spoke on "The History of Chemotherapy and Penicillin Treatments in World War II."

WYANDOT

New officers of the Wyandot County Medical Society are: Dr. John M. Thompson, Upper Sandusky, pres.; Dr. Albert M. Mogg, Upper Sandusky, pres.-elect; Dr. F. M. Smith, Sycamore, secy.; Dr. C. B. Schoolfield, Upper Sandusky, delegate; and Dr. R. J. Semons, Carey, alternate.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

Dr. W. A. Altemeier, University of Cincinnati College of Medicine, addressed members of the Academy of Medicine of Toledo and Lucas County on March 25 on the subject, "The Re-Evaluation of Penicillin Dosage Schedules in Acute Infections."

SANDUSKY

The monthly meeting of the Sandusky County Medical Society was held at Cox's Tavern, Clyde, on March 17. Dr. Maurice G. Buckles, Columbus, was the guest speaker and spoke on "Surgery of Chest Diseases." Dr. H. L. Keiser, secretary, has arranged for wire recordings of scientific papers given at meetings. It is planned that

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these recordings will be used at a symposium at the end of the year.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

"Fractured Ankles" was the subject of a discussion by Dr. Frank M. Barry, Western Reserve University School of Medicine, at a recent meeting of the Ashtabula County Medical Society.

LAKE

Lake County Medical Society had as a speaker on March 19, Dr. Joseph E. Brown, Cleveland, who spoke on "Fractures."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

Dr. Edward W. Miskall of East Liverpool, addressed the March 16 meeting of the Columbiana County Medical Society at Lisbon on the subject, "Symptoms and Signs in Cardiovascular Diseases."

MAHONING

Members of the "Half Century Club" honored recently by the Mahoning County Medical Society meeting in Youngstown, include Drs. M. E. Hayes, A. V. Hinman, W. W. Ryall, C. H. Beight, Harmon E. Blott, C. R. Clark, D. R. Williams, W. D. Coy, C. D. Hauser, R. M. Morrison, H. M. Osborne, C. H. Slosson, and R. E. Whelan.

PORTAGE

An illustrated talk on "Treatment of Burns of the Hand" was given by Dr. George S. Phalen, Cleveland, at the meeting of the Portage County Medical Society March 4 at Robinson Memorial Hospital, Ravenna. "Treatment of Injuries of the Knee" was the subject discussed by Dr. Edwin L. Mollin, of Akron, at the April 8 meeting. The meeting was also held at the Robinson Memorial Hospital, Ravenna.

STARK

"Antibiotics in Upper Respiratory Tract Infections" was the topic of a talk by Dr. C. H. Rammelkamp, Western Reserve University School of Medicine, at the March meeting of the Stark County Medical Society. At the April meeting, Dr. William J. Engel, Cleveland, addressed members on "Urological Investigation of Abdominal Masses."

SUMMIT

The Summit County Medical Society had as guest speaker for the April 6 scientific program Dr. P. K. Champion, Dayton, who spoke on "Office Gynecology."

TRUMBULL

Three members of the Ohio State University College of Medicine were speakers at the

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March 18 meeting of the Trumbull County Medical Society. They were Dr. Stanley O. Hoerr who spoke on "Indications for Surgery in Acute Upper Gastro-Intestinal Hemorrhage"; Dr. Arthur G. James who spoke on "Treatment of Cancer of the Head and Neck"; and Dr. Robert S. McCleery whose subject was "The Use of Anti-Coagulant Therapy of Venous Thrombosis."

Seventh District

(COUNCILOR: R. J. FOSTER, M.D., NEW PHILADELPHIA)

BELMONT

The program of the Belmont County Medical Society on March 18 included a discussion on the subject of "Carcinoma of Breast, Complicated by Pregnancy," by Dr. Richard I. Buttita and Dr. James P. Parlante; and a talk on "Tumor of Spine," by Dr. Harry G. Harris.

TUSCARAWAS

"Meningitis, Its Diagnosis and Treatment" was the subject of a discussion by Dr. J. M. Harkey, Canton, at a March meeting of the Tuscarawas County Medical Society in New Philadelphia.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

MUSKINGUM

"Anticipation or a Surgical Risk" was the topic of a talk by Dr. Donald A. Urban of Zanesville at the March 3 meeting of the Muskingum Academy of Medicine. At the April 7 meeting, Dr. David A. Boyd, Indiana University School of Medicine, spoke on "Psychosomatic Medicine." The meeting was held in the University Club Rooms, Zanesville.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M.D., PORTSMOUTH)

GALLIA

Three projects were approved at the March 25 meeting of the Gallia County Medical Society. The projects were: A proposed "well-baby" clinic in Gallipolis, a new sewer system for Gallipolis, and a Chamber of Commerce drive to destroy disease-bearing insects.

SCIOTO

Dr. Robert M. Zollinger, Columbus, addressed the Hempstead Academy of Medicine at Portsmouth on March 6 on the subject, "Surgery of Colon."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

The April program for the Columbus Academy of Medicine included the following features held at the Columbus Gallery of Fine Arts:

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April 5—Symposium on "Some Common Poorly Recognized Conditions in Infancy," conducted by members of the staff of Children's Hospital. The following topics were discussed: "Tracheoesophageal Fistula," Dr. Karl P. Klassen; "Paroxysmal Tachycardia," Dr. Oliver W. Hosterman; "Persistence of Fetal Posture," Dr. B. R. Wiltberger; "Subdural Hematoma," Dr. K. H. Abbott; and "Congenital Syphilis," Dr. W. E. Wheeler.

April 19—Dr. Harold B. Boyd, Memphis, Tenn., gave an address on "Treatment of Fractures of the Elbow."

April 21—The Section of General Medicine met in the Nurses' Home of Grant Hospital during which discussions were held on the subjects, "The Doctor and the City Health Administrator," and "Academy of General Practice."

MADISON

A case history on "Peptic Ulcer" was given by Dr. W. T. Bacon at a recent meeting of the Madison County Medical Society.

ROSS

Dr. Lloyd E. Larrick, of Christ Hospital, Cincinnati, spoke on "Anesthesia and Its Newer Concepts," at the March 4 meeting of the Ross County Academy of Medicine held in Chillicothe.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

WAYNE

Approval of the basic plans for the proposed new hospital for the Wooster hospital district was given at the March 10 meeting of the Wayne County Medical Society.

Woman's Auxiliary News

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

ASHTABULA

Mrs. Robert J. Bollman, a guest, reviewed *Seventy Miles from a Lemon* by Haydie Yates at the March meeting of the Woman's Auxiliary to the Ashtabula County Medical Society.

FAIRFIELD

The Woman's Auxiliary to the Fairfield County Medical Society met at the home of Mrs. W. D. Nusbaum, Lancaster, in March. The program highlight was an informal talk by Dr. Nusbaum on "Cancer, Its Diagnosis and Treatment."

FRANKLIN

Miss Fern Sharp, Director of Women's Activities for WBNS, spoke on "Round Robin Review" at the March meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, held at the home of Mrs. Phillip T. Knies, Columbus.

CRAWFORD

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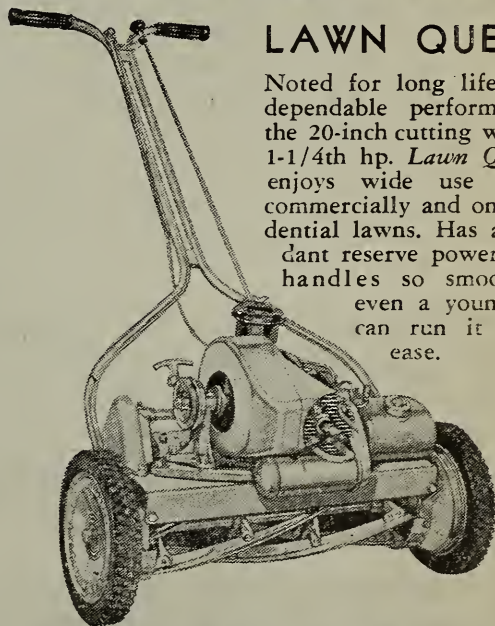
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to the Crawford County Medical Society are: President, Mrs. J. W. Arnold, Jr., Bucyrus; Vice-President, Mrs. Mart Helfrich, Galion; Secretary-Treasurer, Mrs. W. G. Carlisle, Bucyrus; President-Elect, Mrs. John Kidd, Galion. Proceeds from a benefit and rummage sale were used for the Nurses' Scholarship Fund. It is the custom to give a Nurses' Training Scholarship to a worthy student as an outright gift. The expenses for the three years are carried by the Auxiliary which has sixteen members.

HARDIN

On Thursday, March 18, sixteen members of the Hardin County Medical Auxiliary met for a dinner meeting in the Sun Set Inn. Mrs. C. W. Kirkland, Bellaire, was the honored guest.

LICKING

Mrs. William E. Shrontz, Newark, new President of the Woman's Auxiliary to the Licking County Medical Society, announced her commitments for the year at the March 23 dinner meeting in Hull Place.

LUCAS

A very interesting and unusual program was presented at the April meeting of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County. Dr. Ira M. Altshuler spoke on the subject, "Recent Progress in Music Therapy." Dr. Altshuler supplemented his talk by playing music he had composed for use in rehabilitating patients.

PICKAWAY

The terrific wind storm on Friday, March 19, did not hamper or darken the informal social evening and dinner sponsored by members of the Auxiliary when they met with the members of the Pickaway County Medical Society in Pickaway Country Club. Nineteen guests enjoyed the six o'clock dinner served by candlelight.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society has had regular luncheon meetings at the Women's Club in Mansfield. The

main project is to interest the senior high girls in the profession of nursing. Eight or ten girls are interested in the appeal. We are also assisting at the Well-Baby Clinics which are held monthly in the county.

WASHINGTON

Mrs. Vera Gallagher, Marietta Memorial Hospital, spoke on "Know Your Hospital" at the March meeting of the Woman's Auxiliary to the Washington County Medical Association. Mrs. Gallagher told of the \$5,600 collected from the used sales tax stamps since the Auxiliary took over in 1939. Many cases of worthy indigents are helped with the fund.

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The Physician's Bookshelf

By Jonathan Forman, M.D.

Measuring and Guiding Individual Growth, by Ben D. Wood and Ralph Haefner, illustrated by Joseph Paige, (*Silver Burdett Company, New York City*) has been written because our recent war has revealed startling shortcomings in physical fitness, intellectual development, and emotional adjustment. The authors feel that this is due in part to the fact that the schools have failed to recognize the individual differences among learners such as exist in every area of human behavior. Then, too, instruments for measuring these differences have been devised in the last 50 years and the schools have not caught up with these advances yet. On the other hand, the last few years have witnessed the steady growth of methods of guiding human learners in the acquisition of knowledge, skills, and principles of interpretation. These three phases of education must be integrated and used if education is to be modern needs—individual differences, measuring instruments, and guidance. Every physician who is interested at all in our school system—as a parent, a member of the school board, or as a citizen—should take time off to read this work.

Dementia Praecox, by Leopold Bellak, M.D., (\$7.50. *Grune & Stratton, New York City*) gives us a review and evaluation of the present status of our knowledge of the disease in the light of the last decade's work on it. As such, it is a book of considerable worth, especially as the author insists upon taking into account the whole body of the victim as it affects the function of those parts which are obviously working in an unusual fashion.

Fundamentals of Psychiatry, by Edward A. Strecker, M.D., (\$4.00. Fourth Edition. *J. B. Lippincott Company, Philadelphia*) comes out just three years after the last edition to include the psychiatric experiences of the war and eighteen months of the postwar period. Almost two thirds of the veteran-sick load is in the field of neuropsychiatry which this work describes and tries to explain.

Hypnotherapy, A Survey of the Literature by Margaret Brenman, Ph.D., and Merton M. Gill, M.D., (\$4.50. *International Universities Press, New York City*) has been written by these two members of the Menninger Clinic Staff aided by a grant from the Josiah Macy, Jr., Foundation. To the volume published as one of the Foundation's review series in 1944, have been added four detailed case histories and a report of the researches of the senior author.

Be Glad You're Neurotic, by Louis E. Bisch, M.D., (\$2.50. Revised Edition, *Whittlesey House, McGraw-Hill Book Company, Inc., New York City*) was a "best seller" ten years ago when it first appeared. This revised and enlarged edition has been brought out to assist the neurotic state further and more efficiently in the light of new knowledge.

A Primer of Cardiology, by George E. Burch, M.D., and Paul Reaser, M.D., (\$4.50. *Lea & Febiger, Philadelphia*) has been written to acquaint the beginner with certain fundamental principles in the evaluation of patients with heart disease. It is also a practical book placing its emphasis on those problems most likely to be encountered.

Good Health Is Fun, by W. E. Burkard, R. L. Chambers, and F. W. Maroney, (\$1.00. *Lyons & Carnahan, Chicago*) is another health book for boys and girls by these successful teachers and writers. We old folks ought to learn the lesson "Health is Fun".

Clinical Neuro-Ophthalmology, by Frank B. Walsh, M.D., (\$15.00. *Williams & Wilkins, Baltimore, Maryland*) is a huge volume containing the experiences of this well-known student of the eye, who, as a clinician, insists that ophthalmological diagnosis must be based on a general knowledge of disease processes and a detailed knowledge of the ophthalmological feature of diseases.

Reconstruction by Way of the Soil, by G. T. Wrench, M.D., (12s 6d. *Faber and Faber, London, England*) covers an entirely different field from the author's *Wheel of Life*. A scholar with a great personal experience in agronomy, Dr. Wrench's plea for the recognition of natural laws in the symbiosis of soil and civilization is supported by impressive evidence. This thesis is of the greatest importance, not only to agronomists, but to students of politics and to all who are concerned with the future of our damaged civilization.

Farming and Gardening for Health or Disease, by Sir Albert Howard, (12s 6d. *Faber and Faber, London, England*) recounts the results and the implications of researches of this great agricultural authority which began in the West Indies in 1899 and up to a few weeks ago when he died. Sir Albert Howard always kept insisting that diseases should be regarded as messages from Nature that all is not well with our

farming and gardening. If all would heed this message, there would be no shortage of doctors, dentists, or nurses for health would replace sickness. If you want to add ten to fifteen years of robust living to your life, study the writings of Sir Albert and his school in Britain.

Ear, Nose, and Throat: Symptoms, Diagnosis, Treatment, by George D. Wolf, M.D., (\$10.00. *J. B. Lippincott, Philadelphia*) attempts to steer between the brief outline for beginners and the exhaustive works for the specialist. It therefore fits the needs of those of us who are not in the field but who have need to refresh our minds on the modern developments in this specialty.

Epilepsy, Psychiatric Aspects of Convulsive Disorders, edited by Paul H. Hoch, M.D., and Robert P. Knight, M.D., (\$4.00. *Grune & Stratton, New York City*) is the proceedings of the 36th annual meeting of the American Psychopathological Association (1946). It therefore discusses all of the newer knowledge from the clinical approach.

Mind and Body, by Flanders Dunbar, M.D., (\$3.50. *Random House, New York City*) is a book about how people become patients. While it is the current habit to overemphasize the bad influence that mind may have over the body, this author drives home the profound truth that the place to look for health, if you have lost it, is not in the great clinic or in the office of the panel doctor (if he comes to America) but in your own self. If we accept this author's concept that illness does not transform a human being into something less, that he remains as much a person as his healthy brother, then psychosomatic will have real meaning and not be an alibi for our failures.

Psychopathology and Education of the Brain-Injured Child, by Alfred A. Strauss and Laura E. Lehtinen, (\$5.00. *Grune & Stratton, Inc., New York City*) deals with these unfortunate victims who, physically handicapped or not, show intellectual and personality aberrations as a result of injury to the brain. The authors are well-known teachers in the Cove Schools for Brain-Injured Children at Racine, Wisconsin.

Bringing Up Children, by Dorry Metcalf, (\$2.00. *Pilot Press, Inc., New York City*) has been written by a mother. It is a helpful little manual for other mothers and contains chapters on the attitudes of the infant, the two-year old, the child; and some hints on foods and feeding.

Health Instruction Yearbook, 1947, by Oliver E. Byrd, M.D., (\$3.00. Fifth Edition. *Stanford University Press, Stanford, California*) is again the best survey of the year's literature on public health. It is therefore doubly important to

those of us physicians who do little or no reading of the literature in this field.

The Psycho-Analytical Approach to Juvenile Delinquency: Theory, Case Studies, Treatment, by Kate Friedlander, M.D., (\$5.50. *International Universities Press, New York City*) approaches the problem from this new angle and attempts to show which of the problems in this field can be solved by these methods.

The Psychology of Behavior Disorders, A Biosocial Interpretation, by Norman Cameron, M.D., Ph.D., under the editorship of Leonard Carmichael, (\$5.00. *Houghton Mifflin Company, Chicago, Illinois*) shows how experimental psychology is the basis for any sound study of psychiatry, and attempts to bridge the gap between the normal and abnormal because of this relationship.

Origin of Food Habits, by H. D. Renner, (15s Net. *Faber and Faber, 24 Russell Square, London, England*) is a most interesting study. It treats of taste psychology and our approach to foods, the influence of agriculture and climate, the preserving and manufacturing technique, and sociological factors.

Pharmacology and Experimental Therapeutics, 1941-1946, by H. H. Anderson, Fumiko Murayama, and Benedict E. Abreu, (\$6.50. *University of California Press, Berkeley, California*) is a survey designed to bring together significant studies in the field of applied pharmacology during the war years.

The Nation's Food, A Survey of Scientific Data, edited for the Society of Chemical Industry (Food Group) by A. I. Bacharach and Theodore Rendle, (18s Net. *Society of Chemical Industry, 56 Victoria Street, S.W.I.*) discusses eggs, potatoes, vegetables, cereals, meat, fish, and milk as food. Each item is given careful evaluation by an outstanding British authority—32 scientists in all.

Physical Science and Human Values. A Symposium, (\$3.00. *Princeton University Press, Princeton, New Jersey*) in which scientists begin to face social responsibilities and human problems to an increasing degree. There are eight brilliant essays by eight distinguished scholars.

Child Offenders, A Study in Diagnosis and Treatment, by Harriet L. Goldberg, (\$4.00. *Grune & Stratton, Inc., New York City*) is a treatise on the problem child by an attaché of the Domestic Relations Court of Toledo. The author's rich experience emphasizes that truancy is but one symptom of a deeper anxiety all too rarely investigated.

Science in Progress, Sigma Xi Lectureships of 1945-46, (\$5.00. *Yale University Press, New*

Haven, Connecticut) presents ten outstanding lectures on the current progress of science on fundamental problems such as the interior of the earth, the cancer problem, genes, hormones, living cells in action. It will do your soul good to read it.

Your Health and Happiness, W. E. Burkard, R. L. Chambers, and F. W. Maroney, (\$1.08. *Lyons & Carnahan, Chicago, Illinois*) emphasizes for youngsters that the most important way to be happy is to keep well. It is packed full of information attractively presented. It usually takes about 35 years to translate into action the teaching of our school books. This speaks well for the future of our people.

Builders for Good Health, by W. E. Burkard, R. L. Chambers, and F. W. Maroney, (\$1.08. *Lyons & Carnahan, Chicago, Illinois*) teaches boys and girls the importance of using the right building materials for their bodies, building health while they grow.

Medicine Today, The March of Medicine, 1946, (\$2.00. *Columbia University Press, New York City*) is the eleventh series of Lectures to the Laity held at the New York Academy of Medicine. They were devoted to a re-evaluation of present-day methods of medical practice as well as medical education and research.

Some of the conclusions are that medicine's achievements have given us the responsibilities of extending a high quality of medical service to every human being. The present quality of medical training in this country is the best that ever existed, and medicine can meet its responsibilities provided its practitioners are not hampered by controls. If the voluntary hospital maintains its public function there need be no fear for its future. Our present-day general practitioner is capable of handling at least 85 per cent of the illnesses but he must have some contact with 12 to 15 consultants to help him with the other 15 per cent. In research, we can only advance as the basic natural sciences advance. The doctor, the scientist, and the medical examiner are at the layman's service but there are limits beyond which they cannot go and from thereon the responsibility for recovery and health are purely personal. Finally, a restatement of the growing feeling that present methods of paying for medical service and of delivering them have many faults.

Exercise During Convalescence—A Manual of Adapted Exercises, by George T. Stafford, Ed. D., (\$4.00. *A. S. Barnes & Company, New York City*) is a timely text in view of the increased interest in rehabilitation and convalescent care. We shall see even more interest as building costs and the failure to recognize frills, prices new hospital beds out of the market. People will

have to get out of hospital beds into convalescent beds much sooner. At the same time, convalescent patients must be rehabilitated and put back into society. The days when the unsexed female could spend the rest of her days telling of her operation are gone forever.

Men Out of Asia, by Harold Sterling Gladwin, with a foreword by Ernest A. Hooton, (\$4.00. *Whittlesey House-McGraw-Hill Book Company, New York City*) deals with American anthropology. The author attempts in a most interesting way to piece together bones, pots, outlines, and all in a complete picture so that one has something for one's work. Hooton in praising this book gets off one of his classical aphorisms which we medical men can well take to heart. "Scientists who are always afraid of being wrong, some way or other, never manage to be really right."

Advances in Military Medicine Made by American Investigators Working Under the Sponsorship of the Committee on Medical Research, (Two Volumes, \$12.50. *Little, Brown and Company, Boston, Massachusetts*) is a part of the Summary of the Activities of the Office of Scientific Research and Development, and, as such, is of great value.

The work of the Office of Scientific Research and Development, which planned the project, is related in the foreword. The appendix gives a list of hundreds of universities, hospitals, and other agencies and individuals which cooperated. Each section describes what was accomplished and what was left undone in particular parts of the battlefield against injury and disease. Of special interest is the section on aviation, dealing as it does with visual problems, oxygen equipment, and motion sickness. There is also the story of DDT and other insect repellents and rodenticides.

The work of the Committee on Medical Research is outstanding and is therefore apt to mislead us into pushing our Federal Government into research with the hope that it will take the place of our universities which are rapidly becoming too poor to afford the luxury of paying their faculty for anything but classroom work.

Under the stress of war and for a short time, the scientific manpower was mobilized to improve upon almost every phase of medical treatment and much was found out—much more than in the last war. It does not follow that such would be the same if the work of the committee had been extended in time so that bureaucratic jealousy could have had time to develop or to the place where the loose ends and hunches of private investigators have all been used up. It must never be lost sight of that such research can find out which is the best of two known drugs and which is the best way to give the drug and develop many manufacturing methods, but it sel-

dom comes upon any basic contribution such as scientists working in their own laboratories can from time to time discover. All I am trying to say is that while we do honor with these historical volumes to the men who worked for this committee in an effort to shorten the war and insure victory for our side, we must never let anyone sell us the false idea that a Federally-supported Research Foundation is going to get the things done that we must get done if we are to survive as a people.

The Back and Its Disorders, by Philip Lewin, M.D., (\$2.50. *Whittlesey House, McGraw-Hill Book Company, New York City*) is the sixth handy manual in this excellent series of health books written for the guidance of the general public. Certainly there is great need for such a book. All one has to do is to look at the impossible treatment that our women are giving their feet to realize that there must be almost universal misunderstanding about the functions, dysfunctions, and disorders of the back. In addition to the hundred of thousands of women who crowd our offices complaining of backache, the problems of the back proved to be most serious in the basic training work of the Army of the United States as they have been for years in industry and business. Well, here are 150 pages of highly informative material written so the average layman can understand.

The Treatment of Rheumatism in General Practice, by W. S. C. Copeman, M.D., (\$4.00. Fourth Edition. A William Woods Book. *Williams & Wilkins Company, Baltimore, Maryland*) fills a gap which exists in the literature of this field. It surveys the whole field impartially and concentrates upon the practical therapeutic methods which are available to any physician.

Biology for Medical Students, by C. C. Hentschel and W. R. Ivimey Cook, (\$7.00. Fourth Edition. *Longsman, Green and Company, New York City*) is a survey of nature admirably suited to the particular needs of one already practicing medicine or about to enter upon practice.

Our Country and Northern Neighbors, by J. Russell Smith, (\$1.80. *The John H. Winston Company, Philadelphia*) is a text in geography.

You who have not had a chance in a good many years to look into the modern textbook will do well to read this text. Its author is responsible for the modern implementation of the movement to conserve and use more wisely our natural resources. It was he who put the motivating sentences in the school geographies of a generation ago.

This is an important point. If you wish to gain some idea of how your children and grandchildren are going to get along with their neigh-

bors, you can do best to read such texts as this one.

No longer do pupils memorize uninteresting names of cities and rivers or long lists of products which such places produce. Geography today is about people, about people who live in places, and about people using the resources of their places and in so doing meeting problems and trying to solve them.

The Cancer Biopathy, by Wilhelm Reich, M.D., translated by Theodore P. Wolfe, M.D., (\$8.50. *Orgone Institute Press, New York City*) is the second volume of *The Discovery of the Orgone*. It continues to explain orgone biophysics. The author calls upon us to acknowledge the development of living, spontaneously moving substance from other living or from non-living substances, even from orgone energy. In other words, in dealing with cancer, we are directly confronted with the problem of biogenesis.

National Health Program. Hearings before a Sub-Committee of the Committee on Labor and Public Welfare of the United States Senate, Eightieth Congress, First Session, on S. 545 and S. 1320. (*Printed for the Committee on Labor and Public Welfare by the Government Printing Office, Washington, D.C.*) presents nearly 1700 pages, in small type, of testimony on all phases of the proposal to nationalize the American medical profession. A must in your reading if you wish to know the dangers besetting your way of living and that of every physician in this country.

Hospital Care in the United States, by the Commission on Hospital Care, (\$4.50. *The Commonwealth Fund, New York City*) is a study of the function of the General Hospital; its role in the care of all types of illness; and the conduct of activities related to patient service, with recommendations for its extension and integration for more adequate care of the American public.

The Commission recognizes that hospital care, like education, is a personal service which must be organized and effected by the residents of the area who use the facilities. In my opinion, this ought to be shouted at least once a day from the housetops of every town and village throughout the land.

All who are interested in the function of hospitals and how they could be fitted into a system of service; the danger in making the change of putting the hospital administrators in charge of all medical care; and the role of the specialist and the general practitioner of the future, should read and study this book carefully. Every physician should prepare himself with a plan to make our hospitals an integrated system of service within the framework of our American way of life.

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JONATHAN FORMAN, M.D., *Editor*

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Digitalis Intoxication

DAVID H. GREGOR, M.D.

THE advent of the digitalis glycosides with their ease of absorption and lack of gastrointestinal symptoms has increased the occurrence of digitalis intoxication.

The signs of this intoxication may be grouped as follows:

1. The early warning signs of digitalis effects, which in themselves do not indicate definite intoxication or any reason for discontinuance of the drug, but merely demand alertness on the part of the clinician in further administration of the drug. These signs include minimal nausea, prolonged PR interval, a downward sloping of the ST segment with an upward concavity, and bradycardia.

2. Definite signs of intoxication which call for discontinuing digitalis for varying periods of time. It is assumed of course that these signs were not present prior to the digitalis administration, and appeared during the course of the treatment. These signs include nausea and vomiting, colored vision, bigeminal rhythm, numerous ectopic ventricular contractions, and bradycardia.

3. The third group which usually indicates severe intoxication includes second and third degree heart block, marked bradycardia, marked ST displacement, electrical alternans, and ventricular tachycardia.

The following six case studies are presented, not to incriminate any product or any method of digitalis administration, but simply to review the various ways in which digitalis intoxication may mask itself.

The Author

● Dr. Gregor, Findlay, Ohio, is a graduate of Ohio State University College of Medicine, 1941; and former resident in medicine at Kansas City General Hospital, Kansas City, Missouri.

CASE 1

A. S., 2698-D, a 67-year-old white male, 120 pounds, with hypertensive heart disease, myocardial hypertrophy and fibrosis, auricular fibrillation, functional classification of grade III, admitted in acute left ventricular failure.

For many years this patient was on digitalis, gr. 1½ daily. In 1945, he had a typical bigeminal type of rhythm, with ectopic ventricular contractions. No change was made in the dosage. He was readmitted to the hospital on October 21, 1947, in acute left ventricular failure but admission electrocardiogram failed to show any evidence of digitalis intoxication. Daily dosage was still unchanged and three days later Lead 3 again showed bigeminal rhythm with ectopic ventricular contractions. Digitalis was discontinued for four days and then restarted with a program of gr. 1½ five days per week. On this dosage the patient regained his former type of rhythm (auricular fibrillation without any ectopic beats) but still had recurrent bouts of heart failure.

CASE 2

D. B., 7021-D, a 57-year old white male, weighing 185 lbs., chronic pyelonephritis superimposed on nephrosclerosis, with hypertension and hypertensive heart disease. There was myocardial hypertrophy, mild decompensation, functional classification of grade III, and chronic uremia. It was known that the patient had been on digi-

toxin for some previous time, but according to the statement of the patient's personal physician the drug had been discontinued one month previous to admission. Digitoxin was therefore administered rather cautiously in doses of .2 three times a day, or twice a day. Clinical improvement in regard to this patient's edema and tachycardia was not noted, and when a total of 3.0 mg. of digitoxin had been administered within a period of seven days a bigeminal type of irregularity warned the attending physician that digitalis intoxication was present. On October 9, 1947, the admission electrocardiogram showed a regular sinus rhythm, with left axis deviation. An electrocardiogram taken seven days later at which time digitalis intoxication had been clinically suspected. The gram showed in Lead I a number of ectopic ventricular contractions, while Lead 2 showed ventricular tachycardia, a sign of severe intoxication and a mechanism of death. This particular phenomenon has been witnessed in previous cases of uremia indicating that the administration of digitalis in such cases should be approached very cautiously. Undoubtedly there are two factors which play a prominent role in the causation of this sensitivity to the drug. They are: (a) myocardial irritability in the uremic state, and (b) the retention of digitalis within the body tissues due to poor kidney function. The electrocardiogram on October 21, 1947 showed that in spite of the fact that digitoxin was discontinued on the day in which the intoxication was discovered the bigeminal rhythm with the ectopic ventricular contractions had persisted, indicating that the conduction mechanism within the ventricles was still abnormal. The patient died several weeks later from a coronary occlusion.

CASE 3

G. G., 2224-D, a white female, 190 pounds, aged 37, with malignant hypertension, hypertensive heart disease, myocardial hypertrophy, a regular sinus rhythm, moderate congestive failure with a functional classification of grade IV. Patient was admitted to the hospital (already "digitalized") because of acute left ventricular failure.

Emergency treatment in the form of oxygen, venesection, and morphine administration gave rather dramatic results. However, after the patient's initial response the pulse remained extremely rapid, running about 120 per minute, and fine moist rales persisted in the bases of both lung fields, particularly on the left; the patient was in constant need of oxygen administration. Because of this obvious cardiac failure it was felt that adequate digitalization had not been reached on this patient and digitalis was administered three times a day and twice a day for a period of time in the expectancy of a good clinical compensation. After a period of 19 days (in which time 39 cat unit tablets had been administered) with no results either good or bad, gross irregularity was detected in the patient's pulse, and an emergency electrocardiogram was taken. Electrocardiogram on July 26, 1947, (admission) showed the standard limb leads demonstrating the left axis deviation and left ventricular strain to be expected in a patient with this malignant a hypertension. Electrocardiogram on August 15, 1947, taken 19 days after admission at the time when irregularity was first detected, showed the digitalis effect upon this particular patient. The rhythm, while being of a regular sinus in type, with a tachycardia of 130 pulsations per minute, showed in comparison with the admission electrocardiogram a rather marked de-

pression (.15 MV) of the ST segment in Leads 1 and 2, and a marked elevation (.25 MV) in Lead 3. It was felt that this ST segment displacement was due entirely to the digitalis which was discontinued on that date. The possibility of a myocardial infarction having occurred was considered (a Pardee T3 was noted) but repeated electrocardiograms, laboratory work, and clinical evidence failed to support this possibility. The one on September 9, 1947, taken approximately three weeks later showed that the ST segments had again regained their initial admission position. This patient's progress was gradually downhill. The principal diagnosis was considered to be malignant hypertension. Her death occurred approximately one month later. Permission for autopsy was not granted.

CASE 4

J. A., 4064-D, a 65-year-old white male, weight 130 pounds, with arteriosclerotic heart disease, coronary sclerosis, coronary spasm, and possibly old coronary occlusion with myocardial infarction. Patient was admitted because of a right hydrothorax and generalized weakness. He was in congestive failure with the presence of ankle edema, tachycardia of 140, and orthopnea; a functional classification of grade IV. There was no doubt but that this patient had been suffering prior to admission with attacks of angina pectoris. However no evidence either clinical or electrocardiographical was ever found to indicate an acute myocardial infarction. After the fluid had been drained from the right pleural cage the patient was much more comfortable but appeared to be quite weak and had a persistent tachycardia. It was felt that the diagnosis at this time was chronic myocardial failure, superimposed upon a badly damaged myocardium from frequent old myocardial infarctions.

The patient was rapidly digitalized with digitoxin on admission and eight days later because of the persistent tachycardia it was felt that he was not completely digitalized. His maintenance dose of digitoxin was increased from .2 mg. to .3 mg. Three days following this dosage increase the patient showed clinical evidence of a heart block in that his pulse would rapidly change from 50-60 per minute to 100 or 120 per minute. On September 27, 1947, the admission electrocardiogram demonstrated a supraventricular tachycardia of 136 per minute with a regular sinus rhythm; 13 days later after the patient had had a total of 4.2 mg. of digitoxin there was a 2 to 1 second degree heart block. The electrocardiogram taken several weeks after the digitalis had been discontinued showed a return to a normal sinus rhythm. This patient remained off any digitalis preparation for two weeks and was treated mainly with supportive and convalescent care. His progress has been uneventful and good. He is now maintained on digitalis gr. 1½ five days per week.

CASE 5

S. W., 5288-D, a 76-year-old white female, 120 pounds, with arteriosclerotic heart disease, myocardial hypertrophy, moderate congestive failure, as evidenced by acute congestive rales in the bases of both lung fields, exertional dyspnea, and a grade III ankle edema, functional classification of grade III. This patient was admitted because of congestive failure but it was found on admission that she was suffering from a severe digitalis intoxication. Some two and a half to three months prior to admission the patient had been placed on .1 mg. of digitoxin tablets

three time a day. Patient continued during the three months to have the prescription refilled and it was not until she had acute gastro-intestinal symptoms that she presented herself to the hospital for admission. While sleeping her pulse would drop as low as 18 per minute. Admission electrocardiogram on September 9, 1947, demonstrated a 2 or 3 to 1 second degree heart block with ectopic ventricular contractions and a bigeminal rhythm. Three days later, after the digitoxin had been discontinued the electrocardiogram demonstrated varying degrees of heart block which may be seen in digitalis intoxication. Leads 1 and 2 showed a first degree heart block with a PR interval of .32 seconds, which is over 50 per cent increase in the normal PR interval. Lead 3 showed a complete heart block. Ten days later the electrocardiogram showed a return to a regular sinus rhythm of 80 per minute with only mild first degree heart block remaining (PR interval of .23 seconds), and a few ectopic ventricular contractions.

This patient later went into a second episode of congestive failure which necessitated the administration of one cat unit tablet of digitalis daily, 5 days per week, plus mercurial diuretics. Her improvement was satisfactory, and she was discharged from the hospital at a later date, improved.

CASE 6

G. R., 1806-D, a 60-year-old white male, 148 pounds, with luetic aortitis, myocardial hypertrophy, functional classification grade III. This patient was admitted to the hospital on September 30, 1947, for the treatment of congestive failure, at which time his electrocardiogram showed a regular sinus rhythm, left axis deviation, digitalis effect, and evidence of myocardial damage as manifested by slightly increased QRS time between .11 and .12 seconds. The patient responded satisfactorily to the routine management on digitalis, diuretics, etc., and was discharged improved from the hospital at a later date.

Approximately one week after his departure from the hospital, the patient noticed a return of his exertional dyspnea to the degree to which he felt it necessary to consult his local physician who advised the patient to take his digitalis tablets three times a day. This program was carried out for the following week or ten days at which time the patient presented himself to the hospital suffering from nausea, weakness, and with a radial pulse of 34 pulsations per minute. He was in some congestive failure as manifested by a 2+ ankle edema, orthopnea, cyanosis of the nail beds, fine congestive rales at the bases of both lung fields, vomiting, and a very restless type of apprehensiveness. Electrocardiogram on October 22, 1947, taken upon this second admission showed the three standard limb leads demonstrating a complete AV block; the QRS time remained at .12 seconds; and the pattern was not unlike that of a left bundle branch block. The QT interval was 0.73 sec. The patient was given supportive treatment, principally in the form of oxygen and rest, but he failed to respond and 48 hours later died.

Postmortem examination disclosed an enlarged, hypertrophied heart, with sclerotic changes and scarring seen in the proximal aorta and the aortic valve. There was no evidence of acute myocardial infarction or coronary occlusion. It is not presumed that digitalis intoxication alone was the cause of this patient's demise; however, one cannot escape the conclusion that the precipitating factor of this pa-

tient's death was the toxic effect of the digitalis upon an already badly damaged heart.

SUMMARY

Six cases of digitalis intoxication are presented to show the varied ways in which over effect of this drug may manifest itself.

The Neurogenic Bladder

It seems almost unnecessary to point out that it is impossible to characterize accurately a spinal cord or cauda equina injury merely by giving the highest recognizable segmental level of nervous damage and by stating whether or not the lesion is complete. In order to do full justice to this most important factor, it would be necessary to reproduce in its entirety the neurosurgical examination on each patient. This is manifestly impossible, and a very brief method of representation has had to suffice.

The duration of suprapubic cystostomy was chosen for consideration as a factor in the development of a satisfactory bladder, chiefly, because it has been something of a bone of contention between urologists and neurosurgeons in the management of the neurogenic bladder. The data here presented would, at face value, tend to support the neurosurgical view that suprapubic cystostomy has a deleterious effect on the ultimate development of a satisfactory neurogenic bladder. It would be unfair, however, not to point out that such relatively indeterminate factors as the quality of nursing and medical care, the amount of urinary infection, and the general state of nutrition of the patient from the time of injury to the time of these observations are possibly and probably of equal importance. Other factors, such as the presence of multiple decubitus ulcers and the existence of contracture deformities and muscle spasm, also play an important role in bladder recovery.

The general condition of the patient at the time of the observations has been disappointing in prognosticating the occurrence of a satisfactory or unsatisfactory bladder. In the few instances where the relation between the excellent condition of the patient and the occurrence of a satisfactory bladder was apparent, one might wonder justly whether the excellent condition of the patient was the cause or the effect of the satisfactory bladder.

It is noteworthy that more than half of the group of normal reflex neurogenic bladders developed bladder function, which was considered satisfactory by the arbitrary standards employed, without the necessity for transurethral resection. —Willet F. Whitmore, M.D., and Luis M. Isales, M.D., New York City, N.Y. State Jr. of Med., Vol. 48, No. 8, April 15, 1948.

The Laboratory Diagnosis of Virus Infections

ROBERT F. PARKER, M. D.

IN the recent years the general subject of viruses has attracted an increasing number of chemists, biologists, physical chemists, chemical physicists, important statesmen, and others with the result that virus research has become an increasingly expensive and intricate business. Depending on the scope of the project undertaken by a research laboratory the business manager of 1948 will have to provide in greater or lesser completeness the accoutrements of a physical and chemical laboratory, with turbine driven centrifuges, electron microscopes, and muffle furnaces as well as a small zoo and usually a fair-sized chicken farm. To operate the equipment and carry out the investigation there will have to be assembled the usual team of *prima donnas* and their assistants.

As a result of this development a great deal has been learned about the viruses.

PROPERTIES OF VIRUS

We have learned, for example, how the virus particles, or molecules, will settle in a centrifugal field. The principle here is the same as the one which is applied in determining the sedimentation rate of red cells. But here the hematocrit tube must be read while the centrifuge is revolving at 50,000 r.p.m. and the particles are being subjected to a force of 250,000 times gravity. From data collected in this way, it is possible to make deductions as to the size, shape, and specific gravity of the virus particles.

Or it can be demonstrated that viruses will migrate in an electric field. From weird looking diagrams, important conclusions can be derived as to the electrical properties of the surface of the agents and from these other conclusions derived regarding the nature of the proteins and other materials of which they are composed.

Or we may examine crystals of some of the viruses. Study of their photographs has provided much food for thought for protein chemists, as well as virologists.

Or the virus particles themselves may be photographed. It can be shown in this way that different viruses not only behave differently but look different. Some are little round balls, some are little tadpoles with tails, and some are tiny cubes with markings which bear a suspicious resemblance to the spots on dice.

Read before the Section on Medicine at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6-8, 1947. This lecture was illustrated with lantern slides.

The Author

● Dr. Parker, Cleveland, Ohio, is a graduate of Washington University School of Medicine, St. Louis, 1929; member, American Society for Clinical Investigation and the Society of American Bacteriologists; associate physician, Lakeside Hospital; and associate professor of medicine, Western Reserve University School of Medicine.

Or for the metaphysically or chemically minded, there are the problems of the number of viral particles which must enter a given cell in order to infect and the effect of pH and pK on virus stability, or the effect of mass action on neutralization of virus by its antiserum.

But it is perhaps wiser to skip over these interesting topics, and instead to discuss at some length the problems involved in the diagnosis of the viral diseases.

THE DIAGNOSIS

In the differential diagnosis of fevers, there was a time when skilled physicians separated them into "continuous" and "remittent," and subdivided the remittent fevers further into "simple remittent" and "bilious remittent." But for a good many years now physicians have not been content with a diagnosis of "sustained fever," but have demanded more. They did this because they had learned that it made a great deal of difference which sustained fever a sick man had, that is whether their patient had typhoid, typhus, brucellosis, subacute bacterial endocarditis, or tuberculosis, all of which may at times give a sustained or continuous fever. In the same way it will not be long before the physician will want to be able, at least in some cases, to make a more exact diagnosis than to call his acute respiratory infections ARD, or "grippe" knowing that he is filing in one drawer diseases caused by half a dozen infectious agents. At present he labels cases of acute respiratory disease with pulmonary infiltration atypical pneumonia, and includes a half dozen diseases under one head. Acute infections of the nervous system he tags as encephalitis, or aseptic meningitis, and wishes he knew with which of a good dozen diseases he has to deal.

The necessity of exact diagnosis for any

study of epidemiology is self evident. No study worth the paper to write it down on can be done if the disease cannot be precisely identified. In the evaluation of any control measures which are applied, it is likewise self evident that only when it is possible to count noses is it possible to draw conclusions. Further, it is plainly a simple act of faith to give a vaccine for a disease, when it is impossible to diagnose the disease specifically or to separate it from four other similar diseases. In protection of the public health, and enforcing general measures of control when these are available, exact diagnosis may be of the utmost importance. The recent outbreak of smallpox in New York is an excellent case in point. The first case passed undiagnosed by competent physicians, accustomed to dealing with infectious disease. Even the secondary cases, seen by especially trained men and with the possibility of smallpox in mind, could not be diagnosed with absolute assurance from the clinical appearance alone. Here the laboratory provided prompt and positive diagnosis, but I doubt if even in that excellent Health Department more than a handful of men realized that such aid was available, or how it could be secured.

Upon what then does the exact diagnosis of viral disease depend? It depends first upon educated clinical judgment, and lacking this one need go no further. There is no danger that any laboratory test will ever supplant the clinical data, derived from the observation of the patient. In many cases it is possible to make an impressively precise clinical diagnosis from the clinical picture alone. Measles, chickenpox, German measles, when typical, may be written down with an assurance which amounts to certainty. But all practitioners have seen, in the course of a measles epidemic, cases of infection which should have been measles but which never developed a rash, and more than one epidemic of smallpox is an epidemiologic monument to the pitfalls which sometimes beset the diagnosis of chickenpox.

“LA GRIPPE”

In the presence of acute respiratory disease, the best the clinician can do is to say “la grippe,” and retire gracefully. He knows there are six causes for “la grippe,” but has no way to separate them with certainty at the bedside or in the ward laboratory. He can diagnose encephalitis, but from then on must guess as to the exact etiologic agent involved.

In these situations clinical acumen and the routine laboratory can say—“acute infection, due to a virus.” But clinical differentiation between infection with viruses of a given group is not possible—it requires laboratory help and it might be worth while to catalog the ways in

which specific diagnosis of virus diseases is accomplished in the laboratory.

The principles involved in the laboratory diagnosis of viral diseases do not differ from those involved in the diagnosis of bacterial diseases. We may isolate the infecting agent, demonstrate a specific serologic response to infection, or determine a nonspecific serologic response to an apparently unrelated agent or substance when it has been shown that such a nonspecific response correlates adequately with the specific infection.

Table 1 is a list, by no means complete, of locally important diseases which may be diagnosed by the isolation of the agent from a living

Table 1
DIAGNOSIS OF VIRUS DISEASES

Transmission to Animals	
* Influenza A	* Epidemic keratoconjunctivitis
* Influenza B	* Yellow fever
Common Cold	* Lymphogranuloma venereum
* Psittacosis	* Dengue fever
Measles	* Sandfly fever
* Mumps	* Equine encephalomyelitis
Poliomyelitis	Atypical pneumonia
* Rabies	* Louping ill
* Smallpox	* Herpes simplex
Chickenpox	* St. Louis encephalitis
Trachoma	

patient. However, two important qualifications must be added. First, in some of them there is a goodly element of luck involved in the process, even when it is certain that infection with one of these agents is present. Secondly, quite a good-sized zoo would be required to carry out all these isolations. It would include, besides chick embryos and mice which are readily available, monkeys, guinea pigs, rabbits, chimpanzees, and men. I have put asterisks beside the names of those diseases, the viruses of which with luck may be isolated directly in the smaller and cheaper laboratory animals. Overlooking the fact that even in a case of a known virus infection it is not uniformly possible to isolate the virus, isolation of virus directly from the patient has several handicaps as a diagnostic maneuver.

In the first place it is an expensive business. While the use of smaller and cheaper laboratory animals will reduce this, it is a relative reduction. For example we recently had the good fortune to diagnose a case of lymphocytic choriomeningitis by isolation of the virus. So far we have spent \$25 for animals, and to prove that the virus came from the patient and not from our mice will cost another \$15 or \$20. Even to prove that a patient does not have the virus in his C.S.F. costs \$5, and these figures do not allow for any laboratory overhead, or board and room for the animals or the services of laboratorians. The use of chick embryos helps,

since embryos cost ten cents each instead of 30 cents for mice. But for most isolations, ten-day old embryos are used. This means either that the material must be held for ten days while the purchasing department finds a farmer with fertile eggs for sale, or that eggs are put in the incubator on Monday and Thursday of each week to make sure that ten-day embryos will be on hand. Since in a small laboratory there will be few specimens in any week, this program means that a lot of chicks will hatch unless some other program is going on which can make use of the embryos. I must add too that isolation of viruses requires a considerable knowledge of special techniques and that very few laboratories are equipped to deal with all or even many of these agents.

ANALOGY TO BACTERIA

Continuing our analogy with bacterial infections, the next step would be detection of an antibody response to the viral infection. And here we are presented with a choice. The antibody produced in response to infection with a virus which was detected first was the so-called neutralizing, or protective antibody. This antibody, when mixed with virus under proper conditions protects a normal animal from infection. It consistently appears in the serum during convalescence from virus infection, and in some cases can be demonstrated in high titer many years later. The reaction is highly specific, and can be applied to the study of any virus which is experimentally transmissible to animals. The prime drawback to its application in most cases is its cost. Two specimens of serum must be examined, one early in the disease and one in convalescence. A sufficient number of animals must be inoculated in each group to make the result statistically significant. You will readily perceive that here too we have an intrinsically expensive test, but here, as in the problem of initial isolation, progress is being made. The use of small animals and the standardization of the tests have allowed it to be used as a tool for widespread epidemiologic investigation, and it should be much more widely used than it is for diagnosis of individual cases.

Of much greater interest, however, than tests for the specifically protective antibodies, are tests for specific or nonspecific antibodies which will react in the test tube with the specific proteins of the infecting virus. These tests can be performed promptly, inexpensively, and the results as a rule are quite clear cut. In this field there are two general lines of development, both of which promise to add greatly to our knowledge of disease. The first of these is the application of standard complement fixation and precipitation tests. The second depends on

the application of the Hirst hemagglutination test to an increasing number of virus infections.

As is seen in Table 2, in vitro tests of complement fixation or precipitation type are applicable in a number of diseases. A fundamental handicap in tests of this sort is the low titer of antibodies which appears in many cases. This is probably due in part to the fact that only a little antigen actually reaches the antibody producing cells, providing therefore a weak

Table 2
DIAGNOSIS OF VIRUS DISEASES

C. F. or Precipitin Tests	
Influenza A.	Psittacosis
Influenza B	Mumps
Lymphocytic choriomeningitis	Louping ill
Equine encephalomyelitis	Smallpox
St. Louis encephalitis	Yellow fever
Lymphogranuloma venereum	
Hemagglutinin tests	
Influenza A	Mumps
Influenza B	

stimulus. However, with refinement of technic, and the use of better antigens, it is possible that still more names will be added to the list. It should be emphasized that all these tests, like Widal tests, are most valuable when they are applied to paired sera—acute and convalescent—and a rise in titer demonstrated. In fact, in many of the diseases listed, the testing of one serum adds very little usable information.

HEMAGGLUTININ TESTS

At the bottom of the table are placed the hemagglutinin tests, and much time will elapse before this list will be much enlarged. This test has been of great value in providing a quick, cheap, perfectly specific diagnosis in influenza, the disease in which the phenomenon was first observed. The test depends on the observation that the erythrocytes of certain animals are agglutinated by the virus or the virus protein. The nature of the reaction is unknown, but it is known that cells of different species differ in their reaction to a given virus. It is noteworthy in passing that the adsorption of virus by the red cell is temporary, and advantage may be taken of this aspect of the phenomenon to prepare pure suspensions of the virus for use as vaccine. By proper adjustment of reagents, the hemagglutination test may be used to titrate either virus or its antibody. The net result is to provide us with an accurate method for measuring the concentration of virus or the strength of an immune serum which is cheap, accurate, and the results of which are available in minutes instead of days. Using it, sera of patients with influenza, or mumps and soon probably some other infections, may be

examined as quickly and easily as those from patients with typhoid fever, and positive laboratory diagnosis is thus made feasible. It must always be remembered, however, that we are still measuring antibodies, and that that requires testing two sera, one taken early, one late in the disease or in convalescence, and that serologic diagnosis will therefore usually be made in convalescence.

I have tried to sketch some of our rapidly increasing knowledge of the viruses. They are no longer the vague "somethings" of a few years ago, but increasingly well-defined entities, many of them much better known to us than most bacteria. Their study has become big business, involving all sorts of people and producing "statements" on the front pages of local newspapers.

PROGRESS

In the matter of the diagnosis of virus disease also there has been very definite progress. Some of the difficulties attending the isolation of a virus in experimental animals have been outlined, as well as the advantages of serologic diagnosis, and the great advance made possible by the application of the hemagglutination test. By these tests specific diagnosis of virus infections is easy and in many cases cheap. But before you begin taking samples from that "case" you would like to know about, I should add one more word. I know of no laboratory in the country, public or private, which will do these tests for you. At present they are available only as parts of research programs. This means that even in those laboratories set up for them, the doing of an extra test, as a favor, is usually a burden to the laboratory and contributes little but good will to the actual program.

Those of you who served in the Armed Forces will remember that during the war you had at your command a laboratory, a system of laboratories really, which did do all these tests. It was prepared to isolate viruses when feasible, and to carry out the various serologic tests which have been described, and it was of inestimable value. One would like to think that the time is not far off when these facilities will be available to the civilian population as well. These are not cheap laboratories to set up and operate. They are expensive. But it is not necessary for each hospital, or even each community, to have one. One could serve all of Ohio, under the direction of the State Health Department, and it would be used increasingly as it became generally known what it had to offer. The mechanics of arranging for its operation I will leave to the professionals, but I hope you will agree that with aids such as the one I have described available, we cannot neglect their use indefinitely.

Rectalgia Associated with Intestinal Diseases

Among the most trying conditions encountered in the management of intestinal disease is the anal discomfort which so frequently occurs as a major complaint. This discomfort is trying not only for the patient but for the physician as well. Frequently the anal condition so overshadows the basic problem that much effort is wasted and valuable time is lost by directing all attention to the local anal discomfort instead of to the more serious and important disease in more proximal segments of the bowel.

However, experience has taught physicians that it is unwise to direct all the attention to the care of the intestinal disease, for the patient's comfort inevitably assumes an important place in the efforts to control a severe infectious intestinal disease or even the unpleasant sensations associated with the irritable bowel syndrome. Both may be associated with very uncomfortable anal tenesmus or other forms of rectalgia. Once the anal discomfort is controlled, or at least ameliorated, the major problem may be attacked more leisurely or at least with greater confidence from the standpoint of both the patient and the physician.

One may actually be surprised to see a severe diarrhea subside or lessen with the control of a patient's anal disorder, albeit this may have little direct bearing on the treatment of the disease causing the diarrhea. It is rarely wise to indulge in any reparative anal surgical procedure in the presence of intestinal disease but the importance of establishing anal comfort sometimes by the most simple means cannot be overrated. The need for control of anal discomfort has often assumed such major proportions that many symptomatic measures have been invoked including hot Sitz baths, anal irrigations and a variety of local medicaments. It has long been known that ethyl aminobenzoate (benzocaine) has a particularly soothing effect when applied to the anal region of these sufferers. The problem of the method of its application, however, has not been easy. When prepared in the form of a rectal suppository, it can be readily inserted by the patient himself. A suppository containing a soothing mixture of benzocaine, oxyquinole sulfate, balsam of Peru and ephedrine hydrochloride in cocoa butter has proved suitable.

Three groups of patients with as many types of symptoms have been particularly helped by this type of suppository.—J. Arnold Bargaen, M. D., Rochester, Minn. *Minnesota Medicine*, Vol. 31, No. 4, April, 1948.

The Question of Protein Derangement in Diabetic Retinopathy

GERALD T. SCHWARZ, M. D.

RECENT feeling regarding diabetic retinopathy falls into several categories. Some believe that it is only a type of arteriosclerotic disease, but the lesions do not necessarily occur in the region of such disease. Others feel that it is a disease of the capillaries attendant to some toxin that exists with the diabetes. Ballantyne in England in 1944 suggested that the hemorrhages of the central area of the retina were due to tiny capillary aneurysms. He offered some pathologic evidences. Recently it has been shown that there is a definite change in the plasma protein of those patients who had diabetic retinopathy, and there have been improvements in these patients when this condition was corrected.^{1, 2}

INCIDENCE

The incidence of diabetic retinopathy is discussed by H. P. Wagener³ of the Mayo Clinic, who reports that 12.8 per cent of the retinopathies are in patients over forty years of age, and 8.3 per cent in those under thirty years of age. The incidence of retinopathy definitely increases with the duration of the disease. Many times the retinopathy will not be seen until the disease has been present for as long as 15 to 20 years.

Retinopathy in diabetes takes on many forms. There may be hemorrhages alone in the posterior central area. These are of round shape due to their position in the deep retinal layers. The second type includes the first described hemorrhages and also fine hard, white exudates usually about the macular region. These so-called exudates are found to be amorphous, and of a waxy appearance. They are distinct from the cotton-wool exudates which are characteristic of toxic disease, such as kidney disease. Third, a mixture of diabetic and arteriosclerotic retinopathy is frequent, since diabetics frequently have arteriosclerosis. The findings in this combination are those of both conditions combined. Fourth, venous disease showing localized constrictions or beading of the veins, flameshaped hemorrhages adjacent the veins, and dense deposits along the veins, also new vessel formation from the veins themselves. Severe hemorrhages extending into the vitreous may accompany this venous disease. Fifth, new vessel formation other than with venous disease occurs in the formation of new vessels stemming from the disc.

Presented before the Section on Eye, Ear, Nose, and Throat at the Annual Meeting of the Ohio State Medical Association at Cleveland, May 6, 1947.

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TREATMENT

The treatment of diabetic retinopathy, therefore, has been entirely that of diet and insulin, but there are a great number who feel that the lowering of the blood sugar below 150 mg. per cent is definitely contraindicated since it is felt that thereafter the retinopathy is worse.

The general condition of diabetics is better with the administration of vitamin B complex. However, the retinopathy does not improve by this treatment. It is also found necessary to use ascorbic acid and vitamins P in those cases in which it is definitely indicated that there is a deficiency of these two vitamins. The administration of vitamin K is definitely indicated in those diabetics in which there is liver disease, since alteration of liver function causes lack of ability to store vitamin K. The administration of vitamin K helps to bring the prothrombin time to normal. The administration of all the vitamins while it may be necessary for the return of a diabetic to normal condition systemically does not in our experience, particularly influence the disappearance of the diabetic retinopathy.

Lewis, Schneider, and McCullagh in investigations of the protein content of plasma in diabetes found that there was a definite lowering of the serum albumin, and an increase in beta globulin in those untreated patients. In those patients who had no complication of diabetic retinopathy, the protein returned to normal arrangement as soon as the diabetic condition was controlled by insulin. The return of protein level to normal, and the rearrangement of the albumin and beta globulin ratio required a much longer time in those patients with diabetic retinopathy. The return of these patients to normal was slow and only after a high protein diet for several months' time. They have found that there was a reduction of hemorrhages when the protein level was raised to normal. No changes in the exudations were reported. The method of determination of protein fraction was the Tiselius

Electrophoresis method. The normal range of plasma proteins was 3.72 to 5.11, and an average of 4.09 grams/100 milliliters for the albumin, and 0.65 to 1.07 with an average of 0.81 grams/100 milliliters for the beta globulin fraction. The difference in the diabetic patients with retinopathy was as follows: There was a definite reduction of the plasma albumin from the above normal figures, and an increase of the beta globulin to an average of over 1.0 Gm./ml.

PROTEIN LEVEL

The treatment of these patients in order to return the protein level to normal and to re-establish the normal ratio of albumin to beta globulin is more difficult than it would appear at first glance. In the first place those patients do not show the changes in the proteins until the disease has been present for a long time. When the protein of the diet has been increased to well over 100 grams per day, it takes several months for the return of the levels to normal. This action is in direct opposition to the change in the albumin content of plasma after starvation of a healthy, experimental animal, or the return to normal ratio and amounts in a diabetic patient which was untreated, but had no diabetic retinopathy. The diabetic retinopathy is likewise slow in showing change and signs of regression. Our observations have shown that it is a matter of months rather than days or weeks before such changes can be expected. The number of patients observed is not large, but the results are definite and suggestive. An illustrative case of the uncomplicated diabetic with retinopathy is as follows. She is a patient of Dr. M. I. Sparks who has been in charge of the control of these patients. A girl of thirty years of age has had diabetes for nineteen years. Twenty-six months ago sudden loss of vision occurred in her left eye. Observation disclosed a partial thrombosis of the central retinal vein, and large hemorrhages throughout the entire fundus. The right eye showed old scars from previous hemorrhages, and remaining exudates temporal to the macula, typical of diabetic disease. The eye with the thrombosis has cleared under treatment after twenty-five months of high protein diet. It has been twelve months since any round hemorrhages or new exudates have appeared. This patient has developed retinitis proliferans in the left eye in the area of the most severe hemorrhages, but no new vessels are developing, and vision has remained at 20/40 with correction.

A second case in point is one with diabetic cataracts, but with a complicated diabetic condition; that is accompanying liver disease. This patient was operated in December, 1945, after a hospital stay of thirty days preoperatively for the control of her diabetes. The operation was

an uneventful intracapsular extraction, but in the recovery period, on the fifth day, there was a massive vitreous hemorrhage followed by secondary glaucoma. Hemorrhages continued to repeat in this eye for many months, and the Rumpl-Leeds test showed an unusually high figure despite the use of vitamin C, B complex, vitamin K, and vitamin P from natural source (lemon peel). Finally, the addition of high protein diet was given, and in two months the Rumpl-Leeds test returned to near normal. The operated eye has been free of hemorrhages, and the retina has been easily observed for the past six months. There are present in this fundus numerous areas of venous disease typified by sheathing of the veins in isolated areas. Numerous exudates of the waxy amorphous type are still present, but there have been no new hemorrhages for many months until this past month when the patient suffered a high temperature, and severe intestinal upset characteristic of the virus infection epidemic at the time. Regression of these hemorrhages has already begun three weeks after the acute flare up.

Other uncomplicated cases have shown regression of the hemorrhages, and limitation of progress of exudation.

The method of administration of a protein diet as high as this is a problem which cannot be handled by ordinary foods. The material which has been found most successful to date is casec, a protein concentrate manufactured by Mead Johnson from milk protein. The amount of protein has been raised to 150 grams daily in our patients.

SUMMARY

The treatment of diabetic retinopathy now seems to hold some promise. The addition of the high protein diet appears to be a necessary link in the metabolic chain for the restoration of the normal ratio of albumin and beta globulin. There is also definite need for the use of vitamins B, C, K, and P where indicated by the status of the patient and findings of increased capillary fragility and improper liver function. The use of choline where there is liver disease is also indicated.

From all that can be observed, it appears that the disorder of diabetic retinopathy is not per se a diabetic condition, but a manifestation of a concomitant disorder of protein metabolism arising in a body which has suffered from carbohydrate metabolism disfunction.

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Reconstruction of the Distal Portion of the Thumb

ELDEN C. WECKESSER, M. D.

THE thumb is considered the most important digit of the hand. Its amputation is more crippling than amputation of a finger. Hence its reconstruction is of interest to the medical profession.

The importance of the thumb centers around its function of opposition in which it works opposite and against the finger tips. This action allows grasping and manipulating of objects between the thumb and finger tips. The cleft between the thumb and index finger also furnishes a means of grasping large objects and of reinforcing the grasp of the fingers as in turning door knobs, holding tools, and other objects too numerous to mention.

Amputation of the phalanges of the thumb so greatly shortens this structure that most of these functions are lost.

Reconstruction of the thumb has been advocated by Bunnell¹ and others.

The case herein described illustrates the feasibility of reconstruction immediately following traumatic amputation.

CASE REPORT

J. F., age 19, caught his right thumb in a screw machine one hour before admission to Lakeside Hospital, March 20, 1947. The thumb was amputated through the base of the proximal phalanx (Figure 1). The patient was taken to the operating room on admission. Under gas-



Figure 1. Appearance shortly after injury.

oxygen-ether anesthesia the wound of the right thumb was carefully debrided and irrigated with normal saline solution. A single stage abdominal tube pedicle flap was constructed on the right lower abdominal wall using the inferior epigastric vessels as suggested by Shaw.² The

Submitted December 19, 1947.

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free end of this tubed pedicle flap was sutured to the wound of the thumb so that the tube projected in the same line as the shaft of the thumb metacarpal. The arm was immobilized to the side by adhesive tape and bandages. April 25, 1947, a little over a month later, the tube pedicle flap was severed near the abdomen and the free end closed so as to form a projecting tube of soft tissue on the end of the

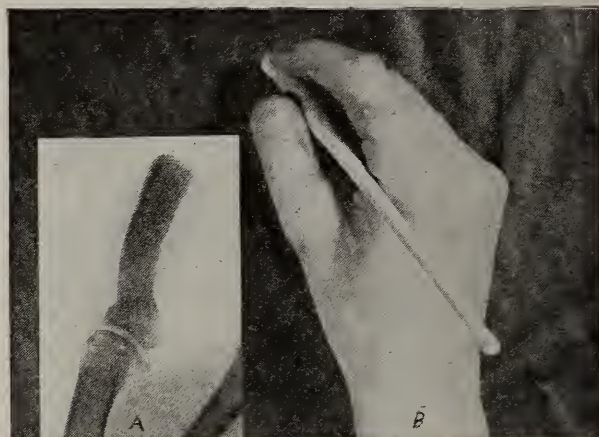


Figure 2. A. Inset shows bone graft in place. B. Appearance after reconstruction.

amputated thumb equal to the length of the thumb of the opposite hand.

Approximately one month later, May 27, 1947, a bone graft from the left iliac crest was inserted into this tube of tissue. This graft was counter sunk into the remaining base of the proximal phalanx preserving the proximal joint of the thumb.

The wounds healed per primam and after eight weeks of immobilization in plaster the bone graft was firm (Figure 2 A).

Figure 2 B shows the appearance of the reconstructed thumb six months after injury (four months after bone graft). At this time the patient was using the thumb very well for all light functions. He was able to button his clothes, open doors, and write. The patient stated that he could write "better than before injury." On November 10, 1947, pinprick sensa-

tion was present to within one and a half centimeters of the tip of the reconstructed structure.

DISCUSSION

It is anticipated that protective sensation will progress to the tip of the thumb. Until that time, the patient must wear a small dressing over its end. Stereognostic sense will not occur since abdominal skin normally does not have this function. However, with pain and touch sensation present in the reconstructed thumb, the structure will have protective sensation and it is hoped that the normal sensation of his finger tips will supply sufficient stereognostic sense. By preserving the proximal joint of the thumb, the patient is able to oppose the thumb to all of the finger tips thus allowing him to carry out fine manipulative movements which his hand would not have had otherwise. The patient returned to light duty August 19, 1947, five months after injury.

SUMMARY

A case of traumatic amputation of the distal portion of the right thumb is presented in which immediate reconstruction was carried out by means of abdominal tube pedicle flap followed by iliac bone graft.

Appreciation is expressed to Dr. William C. McCally, who being occupied elsewhere at the time of this man's injury, kindly referred him to me.

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Deleterious Results of Rest in Bed After Orthopedic Operations

The deleterious effects from bed rest are known to all of us. Speaking from the standpoint of an orthopedic surgeon, the main deleterious effect is, first of all, atrophy, and atrophy not only of bones but also of joints, muscle, fascia, skin, and so forth. The atrophy of bones is manifested by a decalcification; it is actually true that every patient who remains in bed for a period of days begins to lose calcium.

Are the dangers of pulmonary embolism lessened or increased by early activity in fractures of long bones? That, I think, is a difficult question to answer from my standpoint. I believe, if one can prevent the formation of clots in the veins—which is the effort toward which some of our medical confreres are working—that one may say there is no danger in early activity in fracture of the long bones. As long as there is a clot in one of the large extremities, it is probably true that early activity may increase the danger of pulmonary embolism. I am looking forward to the day, and I think some of you feel the same, when we can prevent these clots from forming in some of the large veins.—Ralph K. Ghormley, M.D., Rochester, Minn. Nebraska State Med. Jr., Vol. 33, No. 5, May, 1948.

KEEPING UP WITH MEDICINE

- WAR always burns up our reserves of unapplied knowledge without adding to them at any greater rate than the normal.

* * *

- It should be emphasized that neither penicillin nor any other antibiotic can supplant surgery in the initial definitive treatment of acute appendicitis.

* * *

- PEPTIC ulcer is constitutional. The person with peptic ulcer has a recognizable abnormal composition. Such a patient has a lifelong characteristic susceptibility to the disease. Some of those characteristics are inherited; others, acquired. The acquired factors are largely habits and habits may be modified and often controlled.

* * *

- THE fenestration operation seems to have made it possible to restore practical and lasting airborne hearing in properly selected cases.

* * *

- THE vaginal smear method for recognizing cancer cells is technically simple but requires too much time and skill in interpretation to make it a justifiable screen test.

* * *

- "LIFE depends upon the liver."

* * *

- THE severity of an infection bears no relationship to the penicillin dosage required for treatment. The most serious cases of pneumonia may be caused by pneumococci which are inhibited by very low penicillin concentrations, and a relatively mild bronchitis due to staphylococci might require much higher doses for treatment.

* * *

- A general recommendation of small doses orally in mild infections and intensive dosage in severe infections is therefore fallacious. It is the sensitivity of the infecting organism only, which should determine the dosage, and as a corollary, the route of administration, in penicillin therapy.

* * *

- THE impact of civilization upon the foot of man has been great. Here is a member which, though designed primarily as a dynamic structure, is now called upon to sustain the burden of an existence that is largely static.

* * *

- INFECTED dehydrated food may be fed to farm stock or poultry and thus disseminate in one country pathogenic bacteria which until then had been localized in another.

* * *

- ALCOHOL is said to be the first organic compound to be manufactured by man.—J.F.

Nephroptosis

VICTOR C. LAUGHLIN, M. D..

NEPHROPTOSIS is "the downward displacement of the kidney." Certainly it can be considered as the abnormal motility of one or both of these organs. The term "palpable" and "floating" are also sometimes employed. A palpable kidney is not necessarily a pathological one. The lower pole of the right kidney is frequently normally palpable. A floating kidney is one which floats forward to the anterior abdominal wall. It is frequently entirely covered in a pedunculated manner by posterior peritoneum. Floating kidneys are rare—congenital—and there are few authentic cases on record.

The theory has been advanced that the motility of a ptotic kidney is due to a defect in the lower segment of the perirenal (Gerota's) fascia which permits the kidney to slip down when the individual is erect. This would regard nephroptosis as a herniation of the kidney similar to herniations elsewhere. Normal kidneys move up and down almost 2-5 cm. with each movement of the diaphragm or with each respiration. The term "floating kidney" is the more common name applied to a kidney of abnormal motility. Such terms as "nephroptosis" or "renal ptosis" are also used.

HISTORY

Movable kidney was first described more than 450 years ago (Mense of Venice, 1495). Dietl in 1864 gave it the name "Wandern nieren" or "wandering kidney." In 1846, Royer carefully studied nephroptosis and recognized that it occurred more often in women, and in this sex more frequently on the right side. In 1904, Harris stated that more than two fifths of his patients attributed the mobility of their kidneys to injuries sustained in railroad accidents thereby seeking compensation. In 1859, Dietl described the condition since known as Dietl's crisis. In 1860, Hare advocated the use of elastic abdominal belts as supports for ptosed kidneys. In 1881, Hahn of Berlin performed the first surgical suspension.

There followed in the latter part of the nineteenth century a wave over enthusiasm. Many vague, as well as more serious abdominal complaints were diagnosed nephroptosis. All such patients in whom movable kidneys could be palpated were subjected to nephropexy. The operation was therefore greatly abused. The obvious thing happened—the operation of nephropexy fell into disrepute and these pa-

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tients were surgically neglected. Unfortunately the bias toward surgical repair has persisted to this day.

ANATOMICAL CONSIDERATIONS

The kidney is held in place normally by a loosely fixed fatty capsule which surrounds it. The perirenal fascia encloses it on all sides except at the lower inner part, in which direction the kidney tends to move. The superior pole of the kidney is adherent to the suprarenal capsule. The renal pedicle and intra-abdominal pressure act as anchoring agents.

The descent of the kidney is accompanied by: (1) The perirenal fat; (2) the elongated vessels of the pedicle; (3) the descent of other abdominal organs. Nephroptosis is more common in women with long bodies and small waists than in those with short bodies and large waists.

INCIDENCE

The percentage of individuals who suffer to any marked degree from nephroptosis is low. Abnormal mobility of the kidney has a higher incidence in women, the ratio being 10 to 1. This means that it is found in 20 per cent of women and only 2 per cent of men.

When unilateral nephroptosis exists it is the right side which predominates. This is especially true in women. In men it occurs with equal frequency on either side.

Concerning age, nephroptosis is seen in young girls occasionally. It is usually seen after puberty, the greatest incidence being between the ages of 30-40. Thereafter the number of cases declines as age advances. Quite a number of abnormally mobile kidneys are seen in elderly people and even at advanced ages, especially in women.

In a series of 100 cases of movable kidney the right kidney only was found ptosed in 70 per cent; the left kidney only in 10 per cent; both kidneys in 20 per cent.

In the middle of the nineteenth century, Dietl

expressed the opinion that nephroptosis occurred 100 times more frequently in women than men and Glenard gave the ratio as 100 to 12.

ETIOLOGY

The causes of nephroptosis may be divided into two classes: (1) Predisposing; and (2) active or exciting causes.

Predisposing causes: The difference in the body form of the woman has already been mentioned, her usually narrow chest and flared hips. This may also be present in a less extent in certain men. Other predisposing factors include: weakness of the abdominal wall through pregnancy, emaciation, posture, enlargement of liver and/or other organs, and shallow renal fossae.

Active or exciting causes: Repeated pregnancies; certain occupations involving lifting, jolting, and abnormal positions; injuries; blows received; under-exercise; poor nourishment and loss of perirenal fat; sudden, violent muscular exertions; long hours standing; and tight lacing.

The anatomically longer renal pedicle on the right side, the crowded condition of the upper right quadrant of the abdomen together with the pressure being transmitted to the kidney during respiration probably predispose the organ on that side to a higher incidence of ptosis than its partner on the opposite side.

SYMPTOMATOLOGY

Two groups of cases to be differentiated. Nephroptosis without symptoms or functional disturbances and nephroptosis with symptoms.

Nephroptosis becomes symptomatic when free urinary drainage is impaired or the renal blood supply or nerve supply is abnormally involved. Symptoms may be divided as follows: urinary—reflex, gastro-intestinal, and nervous. They may also be divided as (1) primary, (2) secondary or reflex.

PRIMARY SIGNS AND SYMPTOMS

(1) Dull, aching pains in the affected side. These pains may or may not radiate and are often relieved by rest in bed.

(2) Severe kidney colic—Dietl's crises. These attacks are most severe, the pain radiating from the ileocostal angle down the ureter, either into the lower abdomen, or external genitals. The patient is quite ill, and is relieved only by large doses of opiates. Since nausea, vomiting, and abdominal distention are common symptoms, this lesion is often mistaken for some abdominal crisis.

(3) A chronic pyelitis may be the only symptom, the accompanying stasis preventing the infected kidney from getting well.

(4) A severe neuritis is sometimes a most annoying symptom.

(5) Hematuria may occur as a result of congestion.

(6) There may be frequency, tenesmus, dysuria, albuminuria, poor drainage, and infection.

SECONDARY OR REFLEX SYMPTOMS

(1) Digestive disturbance with symptoms simulating such conditions of the gastro-intestinal tract as: ulcer, cholecystitis, chronic appendicitis, etc., are often manifestations of right kidney disease.

(2) Pain may appear in various places, this is accounted for by: reno-gastric, reno-ovarian, renotesticular, renorenal, reno-urethral, and other reflexes. Renorenal reflex pain is sometimes felt in the opposite kidney. The kidney becomes tender and painful whenever it leaves its bed ordinarily.

(3) Neurasthenia with low blood pressure can result from a thinning of the adrenal gland caused by the continuous pull of the low kidney and embarrassed circulation. Loss of weight may be considerable.

SYMPTOMATOLOGY IN GENERAL

The symptoms of nephroptosis are usually characteristic and proportional to the underlying or complicating pathology. Any infection may persist because of poor drainage. Orthostatic albuminuria seems to bear a direct relation to nephroptosis. Considering the visceroptosis, particularly the splanchnoptosis, constipation may be an annoying symptom. In rare cases, the spleen, in close association with the left kidney, is liable to confuse the diagnostic picture. In some instances the kidney may even descend into the pelvis and press upon the bladder and in females upon the generative organs giving rise to bizarre symptoms. A severe case of menorrhagia has been reported cured by anchorage of the patient's ptosed right kidney. Functional digestive disturbances have been referred to. We have encountered a very high incidence of reflex gastro-intestinal symptoms in patients with chronic upper urinary tract lesions.

Obviously the neurasthenic and psychic factors loom very large in these cases. Hysteria and hypochondria have been known to clear after surgical correction. The patient subjected to manual labor, strains, repeated trauma, repeated child bearing, and long hours standing presents one set of symptoms whereas nephroptosis among brain workers and those of less strenuous occupations and the leisured class often present quite a different symptom picture.

The "dragging down" pain, dull, aching in character, associated with backache which comes on particularly after fatigue or standing for long periods is somewhat characteristic. The pain

may be referred to the loins, down the lateral aspects of the abdomen, possibly to the genitals. Their severity depends upon the drag on the pedicle and the degree of obstruction and retained urine. The symptoms may resemble appendicitis and other acute intra-abdominal pathology.

PATHOLOGY

Classification: For clinical purposes the degrees of renal ptosis may be arbitrarily grouped as follows:

Lower pole palpable.....First degree
Entire kidney palpableSecond degree
Entire kidney palpable and movable
in all directionsThird degree

Abnormal movability or motility is not in itself pathological. The blood supply and other structures involved in this condition adjust themselves so readily to changes of position that there is frequently no functional or symptomatic disturbance.

Varying degrees of renal degeneration may occur in the pelvis and parenchyma. However, usually the pathological changes are slight until the obstructive or infectious element becomes advanced.

Strictures, constricting bands, and stenosis may occur along the urinary pathway, under which conditions obstructive pyelectasis (hydronephrosis) may occur. Well-established hydronephrosis seldom occurs however.

With greater degrees of mobility the ureter is less apt to become obstructed as in such instances kidneys move away from aberrant vessels or bands which might obstruct.

DIAGNOSIS

The first step toward diagnosis is a carefully taken case history. An attempt should be made to elicit the characteristic symptoms but of more importance is the aggravation and amelioration of these symptoms. It is good practice to ask the patient if the symptoms are better after rest on rising in the morning only to become worse as the day goes on, relieved again by lying down during the day or putting on the properly fitting abdominal support or ptosis belt.

In slender individuals, bimanual palpation of the upper abdominal quadrants in the reclining and upright positions frequently confirms the presence of an abnormally mobile kidney and differentiates it from other tumefactions.

Retrograde pyelograms, renal pelvis emptying time, and intravenous pyelograms may be helpful although the latter seldom supplies the detail evidence upon which to base the serious consideration of surgical correction.

Urinary findings vary greatly. When uncomplicated by infection, urinalysis may well be within normal limits, whereas, after infection has taken place, pus, blood, and bacteria are found. A negative urinalysis does not necessarily rule out kidney pathology as the pathological side may be completely obstructed.

Nephroptosis is to be sharply differentiated from ectopic kidney which condition is characterized by an abnormal vascular and fascial attachment present since birth and by virtue of such attachments has always been fixed in an abnormal location. Such a kidney never was in normal position.

Abdominal tumors and retroperitoneal growths must also be differentiated from nephroptosis. This is not always easy. The movable kidney has the customary attachments but owing to their unusual length and looseness the organ is allowed an abnormal excursion. In thin individuals the hand may be pressed in above the upper pole entrapping the kidney in its descended position. This reproduces or aggravates the pain which is important to diagnosis.

Nephroptosis may be a part of a splanchnoptosis which obviously includes a low stomach, transverse colon perhaps in the pelvis, and a liver which comes to the crest of the ilium when the patient is standing.

DIFFERENTIAL DIAGNOSIS

The symptoms due to gallbladder disease, gastric and duodenal ulcer, chronic appendicitis, colitis, etc., may be confused with those produced by a lesion in the right kidney. These diseases are not infrequently found coexisting with ptosis of the kidney. The referred pains of pelvic lesions in women and prostatic and seminal vesicular infections in men, may occasionally be confusing.

Retrograde pyelo-ureterograms or intravenous pyelograms in both the reclining and upright positions are now orthodox procedures. Inspiration and expiration pyelograms, while informative, are not conclusive. Because of the toxic reactions associated with acute retention, all contrast media should be of a type suitable for intravenous use. We use 20 per cent skiodan routinely for all retrograde pyelograms. Retention of such solutions is not followed by serious complications.

It is better to withdraw the urethral catheters before taking the upright films. In this way any splinting effects are eliminated.

The overdistention of the renal pelvis will sometimes reproduce a pain which the patient will describe as characteristic of his or her complaints. Complete roentgenological examination should be re-enforced by the application of well-known tests of renal function.

During the past 20 years there has been a very marked advance in diagnostic methods. This has made it possible to determine which of well-selected cases gives promise of satisfactory results through nephropexy.

TREATMENT

Two divisions of treatment are recognized: palliative and curative.

Palliative: This division of treatment embraces rest in bed. Under such circumstances the kidney frequently floats back into some semblance of normal position. Tensions and torsions, as well as obstructive changes within the pelvis (varying degrees of obstructive pyelectasis or pyelonephritis of both), are sometimes relieved. A free flow of urine is the first principle in the elimination of infection. Perinephritic adhesions frequently prevent the kidney from resuming its normal position and relief of symptoms.

Instrumentation, indwelling ureteral catheters, and/or urinary antiseptics of various types may be helpful. Before considering surgical corrections it is well to observe the results of a properly fitting, individually tailored, abdominal lift garment. Obviously such garments make no permanent change in the anatomy. They only serve efficiently so long as they are kept properly adjusted and maintain their strength and lift qualities. Stock garments have not been too helpful.

Focal infections in other parts of the body must be eliminated. This is very important before surgery is instituted.

Curative: Nephropexy alone will be sufficient in most cases. A complete urological examination to exclude associated congenital or acquired abnormalities is absolutely essential. Think how terrible it would be to perform an operation of this kind on a tuberculous kidney or to get inside the patient's body before learning that the ureter is too short to allow the kidney to be placed in normal position. There are many such pitfalls awaiting the casual operator. Anomalies of blood vessels, constricting bands, stones, chronic infections—all must be known in advance of the operation.

Some authorities believe that visceroptosis is always associated with nephroptosis, while others state that in the majority of these cases there is no displacement of any other organs. In our experience we have found the two conditions associated numerous times but have not found visceroptosis a serious contraindication for nephropexy.

There are numerous methods for fixing the kidney in normal anatomical position. They include mattress sutures through the paren-

chyma, supports made from portions of the renal capsule, ribbon gut suspensions, supportive treatment of Gerota's fascia, and many others. It is particularly important whatever method is used that nephrolysis and ureterolysis be complete before the operator can expect to place the structures adequately and properly in position to perform physiologically. Small aberrant vessels may have to be divided. A kidney too securely anchored may give rise to more pain than the condition for which the patient was operated for it will be remembered that normal kidneys are movable kidneys which must be allowed to move upward and downward with respiration.

Patients frequently tell us that their family physicians have cautioned them never to have their "dropped kidneys" operated, stating that there is a very high incidence of recurrence. Such opinions are antiquated. We have re-examined with X-ray many of our postoperative nephropexys in the upright position with contrast material in the renal pelves and have not yet observed a recurrence. This is no exaggeration.

Pyeloplastic procedures are occasionally required at the time the suspension is done. If the kidney has been too badly damaged, it may be removed. A previously determined knowledge of the exact functional status of the opposite kidney is not only valuable at this stage of the procedure, it is mandatory. To operate a patient under any other circumstances is malpractice. Many of these severely-crippled organs, however, will regain a large part of their normal function after being freed, repaired, and properly anchored.

SUMMARY

During the past twenty years there has been a marked general improvement in diagnostic methods. Urology has contributed materially to this improvement. It is now possible in well-selected cases of nephroptosis to determine pre-operatively which of these organs will give the most promise of satisfactory results following nephropexy. The professional bias which had its origin in a period of over enthusiasm for this operation in the latter part of the nineteenth century is no longer justifiable.

Following Dietl's contribution (1859) abuse of the operation caused it to fall into disrepute. The result has been that surgical correction is sometimes denied patients in whom it is rightfully indicated. The pendulum has now swung back. The operation of nephropexy is now an accepted therapeutic, surgical procedure, provided orthodox methods of diagnosis and acceptable operative techniques only are employed.

Clinical Interpretation of X-Ray Pelvimetry

HOWARD P. TAYLOR, M. D.

X-RAY pelvimetry is our most reliable source of information concerning the shape and size of the bony pelvis and the fetal head. A critical clinical study of the roentgenograms by the obstetrician after the roentgenologic interpretation is an essential, but frequently neglected, step in the proper utilization of this potent aid to clinical diagnosis. Roentgenograms should be used only as an adjunct after tentative diagnosis has been made and an opinion formed as to the proper conduct of a given case.

The three factors primarily concerned with the course of labor are: (1) The forces of labor; (2) the passages; and (3) the passengers. X-ray study is principally concerned with the second factor, and to a lesser degree with the third, the passenger itself.

EXTERNAL PELVIMETRY NOT ACCURATE

Most observers agree at the present time that external pelvimetry is of but little use in determining actual pelvic capacity. It seems clear that if pelvimetry is a valuable procedure at all, we must have accurate observations. In the living woman it is impossible to secure such data except by means of roentgen technics. Schuermann states in his Textbook of Obstetrics, "As a teacher, I feel so strongly on this subject, that it is with some reluctance that I continue to emphasize clinical pelvimetry to my students, since I am convinced of its inadequacy except in cases of gross deformity." We are in complete agreement with Schuermann as far as measuring of the inlet and midpelvic plane are concerned, but feel that clinical measurement of the pelvic outlet is more accurate and revealing than X-ray study of that region. If outlet pelvimetry were done in every case the obstetrician would be in better position to correctly interpret the roentgenograms and would encounter fewer sad surprises at delivery.

It is, of course, evident that most women have pelves which are adequate for delivery of most babies, but scientific obstetrics cannot be conducted on any such philosophy, for applied to the individual case it is obviously fraught with danger. Most obstetricians of experience will recall instances where unsuspected midplane contraction or other pelvic abnormality was responsible for a difficult operative delivery, often ac-

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companied by loss of the baby. The use of antenatal pelvimetry anticipates many such difficulties. This does not mean that such patients should be treated radically, but it does mean that such patients are more likely to receive treatment modified to suit a situation which is well understood. Statistics from clinics where pelvimetry is used extensively all reveal a marked decrease in the incidence of Caesarean section due to disproportion. Nothing dispenses the clouds of doubt and fear as effectively as the illumination afforded by accurate knowledge.

ROUTINE X-RAY PELVIMETRY UNJUSTIFIED

Recourse to routine X-ray pelvimetry in the average obstetric practice, as advocated by some authors, is neither desirable nor justified. Because roentgenograms are so easily obtained, many physicians rely on them rather than a thorough physical examination and clinical judgment for the diagnosis and management of obstetric cases. This is a serious error for it very frequently results in gross mishandling of the patient. Experience justifies the assumption that when at the end of pregnancy the fetal head has descended to midpelvis or lower, when the pubic arch is not narrowed and the transverse diameter of the outlet is good, vaginal delivery is possible and X-ray measurement is unnecessary. On the basis of our experience we feel that all primiparas with unengaged heads two weeks prior to term, all breech presentations, all compound presentations, and all multiparas with history of previous difficult labor or delivery should be subjected to searching X-ray studies before the onset of labor. X-ray examinations during labor should be done without hesitation if arrest occurs in a multipara, for second or third babies may be considerably larger than the first and cephalo-pelvic disproportion may occur. No well-equipped maternity can afford to be

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without adequate facilities for intrapartum roentgen pelvimetry.

At least ten different technics of pelvimetry have been devised and carefully described by their authors. In the hands of roentgenologists who understand the procedures accurate results may be obtained. Weinberg and Scadron report a comparison of roentgen technics obtained by measuring each of 100 patients by four different methods, all of which gave results within 0.1 cm. of each other. It was concluded that the method used was less important than experience in using that method. Generally speaking the method selected should be adapted to the ability of the roentgenologist and his equipment. All technics so far described may be classified either as qualitative or quantitative. The qualitative methods, as exemplified by the precision stereoscopic procedure has for its advantage that it reduces pelvic description to linear measurements which are identical with those used clinically and also admits morphologic classification of the pelvis, with which most clinicians are now familiar. Ball's method is an example of the quantitative procedure, which merely expresses the cubic capacity of the pelvis in relation to the cubic content of the fetal head, which to the average clinician has little meaning, and is therefore less widely used.

PELVIC MORPHOLOGY

It is only in the past few years that X-rays have been applied to the study of pelvic shape. The early examinations were more or less limited to attempts at deriving measurements of the pelvic inlet. At present there are two morphologic classifications of the pelvis in use. That of Caldwell, Moloy, and Swenson, and their coworkers is widely used and is based on very careful attention to X-ray study of pelvic shape which they correlated with assembled dried specimens. They distinguish five main groups of pelvis: Gynecoid, platypelloid, anthropoid, android, and assymetrical. They further subdivide them into mixed types. For example, a pelvis may assume the combined characteristics of any two parent groups. This is not as difficult to understand as would first appear, for when we combine the measurements with the shape of the inlet, midpelvis and outlet the problem is simplified. The more recent, and less known, classification suggested by Thoms is based on the pelvic index which is the ratio between the anteroposterior and transverse diameters of the pelvic inlet. In the future this classification may be widely used, and for that reason is briefly mentioned: The dolichopellic type has an elongated oval inlet; the mesatipellic a round inlet; the brachypellic, a slightly flattened oval inlet; and the platypellic, a flat oval inlet. So long as the roentgenologist and

obstetrician are both thoroughly familiar with the classification used and the implications of each type of pelvis, the classification selected is of little importance.

The roentgenographic report should include a general description of the development and approximate size of the fetus, its presentation, position, and attitude, the degree of descent of the head. Fairly reliable measurements of cephalic diameters can usually be obtained and should include the occipital-frontal, biparietal and suboccipital-bregmatic diameters. Interpretation of any observable soft tissue shadows should be given. A morphologic classification of the maternal pelvis is made and actual measurements of the various pelvic diameters done.

The pelvic diameters which are of importance are as follows: The anteroposterior of the inlet, which is a line drawn from the upper, posterior border of the symphysis to the sacrum at a point where the iliopectineal lines would converge were they extended. The widest transverse diameter of the inlet; the anteroposterior diameter of the midpelvic plane, which is a line drawn from the lower, posterior surface of the symphysis posteriorly through the level of the ischial spines to the lower sacrum. The transverse diameter is the distance between the ischial spines. The intertuberous diameter of the outlet and the subpubic-sacral distance are determined. The width of the forepelvis, the character of the sacrosciatic notch, the angle of the pubic arch, slope of the pelvic side walls as well as the direction and curve of the sacrum should be mentioned.

William and Phillips have shown that radiographic predictions of the outcome of labor may be relied upon only when no evidence of disproportion is apparent. In cases of severe disproportion predictions were sixty per cent correct, when there is moderate disproportion, accurate predictions dropped to only fifty per cent. In view of these statistics it is most unwarranted for the roentgenologist to recommend the termination of labor by specific operative procedures. He should be satisfied with one of three conclusions, namely: (1) No evidence of disproportion; (2) evidence of moderate disproportion; and (3) severe disproportion. The clinical interpretation is definitely the responsibility of the obstetrician and the roentgen report must be modified by him in consideration of the clinical aspects of the case.

Errors in roentgen predictions have led some clinicians to deride the value of this procedure. Obviously no one can estimate from the X-ray plates how much of the available space of the pelvis is occupied by soft tissue, which in muscular women may be considerable. The behavior of the cervix during labor cannot be foretold. The degree of molding of the head during labor

cannot be determined. The age of the patient and her previous gynecological and obstetrical history is unknown, and above all, the skill of the attending obstetrician is an unknown factor of greatest importance. These facts form the basis of our contention that roentgen pelvimetry must be considered only a valuable diagnostic adjunct and not a substitute for mature obstetric judgment.

CLINICAL CORRELATION

Upon completion of the roentgen study the obstetrician must correlate this information with his clinical findings to shape the proper course for the conduct of labor and delivery. Actual study of the roentgenograms is a necessary step in this procedure and must never be omitted. During this survey the dictum of Caldwell and Moloy must be uppermost in one's mind. "The fetal head in its descent attempts to adapt itself to that diameter of the inlet most suited for its reception. If arrest occurs and operative delivery becomes necessary, the fetal head must be made to pass through that pelvic diameter most suited for its reception."

The obstetrical interpretation differs from the roentgenological study in that the obstetrician is not primarily interested in determination of measurements, but by correlating the information available in the stereoscopic views of the pelvis plus the lateral, erect view and the outlet projection he is able to deduce which cephalic diameter is likely to present and which pelvic diameters offer most suitable space for reception of the fetal head. It is well to remember that the biparietal and suboccipital-bregmatic diameters are those usually concerned in the passage of the head through the pelvis. Once the obstetrician becomes familiar with the pelvic architecture he will quickly recognize arrested labor and will be able to deal with it intelligently. We must not fail to remember that the final test for disproportion lies not so much in the exact size of the maternal pelvis, but in the ability of the fetal head to pass through it.

In our experience pelvic architecture based on Caldwell and Moloy's classification gives invaluable aid in the conduct of labor and delivery.

LABOR IN VARIOUS TYPES

Labor in the gynecoid type of pelvis is usually uneventful, for this is the ideal type of pelvis for child bearing. In the small, generally contracted forms there may be moderate cephalopelvic disproportion. Under the influence of good labor pains the head usually will mold into the inlet either in the transverse or oblique diameter. Ordinarily there is ample room in mid pelvis for the head to rotate to an anterior position and engagement under the relatively broad pubic arch occurs without difficulty. If the head fails to engage in the inlet, relatively

severe disproportion exists and Caesarean section occasionally becomes necessary.

In the anthropoid pelvis engagement occurs frequently in the anteroposterior diameter, since the widest transverse diameter of the pelvis is near the sacrum, the occiput not infrequently is posterior. Good uterine contractions will cause the head to descend in a posterior position to the pelvic floor. There, if the pubic arch is ample, the head rotates to an anterior position. Arrest above the pelvic floor should not be treated by rotation of the fetal head, for it is mechanically incorrect to rotate the head from a larger diameter through a smaller one. Version is usually the operation of choice.

Characteristically the platypelloid pelvis has an inlet shaped as a flattened oval. The head enters in the transverse diameter and descends in that diameter until the pelvic floor is reached. Rotation then may occur if the pubic arch is ample enough to accommodate the occiput.

The android pelvis, having a heart shaped inlet, usually permits engagement either in the transverse or oblique diameter. Since the hind pelvis is more ample than the forepelvis, the occiput frequently rotates posteriorly. Since there is a general convergence of the four walls of the pelvis toward the outlet, the head meets with increasing resistance as it descends. If uterine contractions are strong and the fetal head is capable of molding delivery may be successfully carried out from below. However, in severe forms of this type of pelvis Casarean section may sanely be advised.

Unless there is absolute contraction of the pelvis a test of labor may be safely elected. It is not unusual to encounter a case of apparent disproportion when pelvic and cephalic measurements are considered alone. Favorable pelvic shape combined with good labor contractions often result in uneventful labor. If engagement does not occur after adequate trial a Caesarean section may be done without having damaged mother or baby. We do not believe any borderline case of inlet contraction should be sectioned on the basis of X-ray measurements alone.

If there is narrowing of the mid pelvic plane to a moderate degree careful observation of the patient until the head has passed the narrow point is necessary. If arrest occurs at this level selection of the proper method to terminate labor depends upon many factors. If the cervix is fully dilated and the outlet is adequate, carefully assisting the head through the narrow area with forceps may be possible. If the operator is skillful in the use of podalic version and breech extraction, that method may be elected, especially in the anthropoid type of pelvis. If, however, the pelvis tends to funnel, even though the cervix is fully dilated, it may be wise to term-

inate labor by Caesarean section knowing that the head will be encountering progressively smaller diameters on its downward passage.

As indicated earlier in this discussion, the outlet can be measured with satisfactory accuracy clinically and should be a part of the prenatal examination. J. W. Williams states that when the sum of the transverse and posterior sagittal diameters is 15 cm. or less delivery cannot be expected per vaginam. An elective section may be done with the onset of labor. Not infrequently severe contraction of the outlet is first noted at the time delivery is attempted. No criticism can be made if vaginal delivery be abandoned and a laparotrachelotomy elected as a safer means of delivery.

The management of labor in breech presentations is determined to a large extent by comparison of the cephalic and pelvic measurements as well as pelvic architecture. Simmons has shown that the wedge of the after-coming head frequently permits easier delivery than the blunt vertex. In proper hands breech extraction can be accomplished even though there is slight cephalo-pelvic disproportion, for under direct control of the hands the most favorable cephalic diameters can be made to present and the head can easily be directed into the most ample region of the pelvis. In cases where there is considerable disproportion, or unfavorable pelvic architecture Caesarean section is the operation of choice.

Transverse presentations usually require Caesarean section to avoid uterine rupture in the primipara. A short test of labor may be given multiparas who have had previous normal pregnancies and labor. One recent case of transverse presentation, terminated by section, was found to have a subseptate, bicornuate uterus. Fortunately a transverse laparotrachelotomy was elected rather than a classical procedure for the uterine incision of the latter would have penetrated deeply into the septum before the condition could have been recognized.

COOPERATION ESSENTIAL

As we gain experience in the field of X-ray pelvimetry we are more thoroughly convinced that proper evaluation of each case can be obtained only by close cooperation between the roentgenologist and obstetrician. It is the responsibility of the roentgenologist to familiarize himself with a roentgen technic which renders reasonably reliable measurements, permits morphologic classification of the pelvis and observation of the fetal skeleton. He should report the measurements, pelvic shape, and an estimate of possible disproportion. It must be emphasized that dogmatic predictions of "things to come," or not to come, by the roentgenologist and a meek acceptance of this opinion by the obstetrician

can result only in errors of omission or commission not commensurate with good obstetric practice. Thorough utilization of information obtained by adequate history, thorough physical examination and X-ray pelvimetry plus good obstetric judgment based on knowledge of the mechanisms, of labor, the forces of labor and pelvic anatomy combined with skillful ability to carry out major obstetric operative procedures will bring the case to a happy conclusion.

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Diverticulosis and Diverticulitis of the Colon

Diverticulosis of the colon is rarely congenital. Edwards postulates that "in every hernia two conditions must be present: (1) an area of diminished resistance in the wall of the cavity—this area of weakness through which herniation occurs is provided by the passage of a blood vessel; (2) a pulsion force in the lumen of the cavity—(a) the pressure of the contents. (b) contraction of the muscular coat." The latter factors are interdependent. It is contended that diverticula result from irregular spasm of the bowel musculature maintained over a long period of time, and that hernial orifices, through which the mucous membrane is forced, are provided by the gaps in the musculature through which the blood vessels pass. Constipation apparently does not play a role in the pathogenesis unless spasm of the bowel is also present. There are many references in the literature concerning possible predisposing factors such as overdistention of the bowel, hard coarse fecal material, degenerative changes, and obesity, but the significance of most of these factors is pure conjecture.

The exact cause of diverticulosis of the colon is not known. The pathogenesis has been discussed, but the etiology must await further studies of bowel physiology and factors which cause prolonged bowel spasm.—Robert W. Quinn, M.D., New Haven, Conn., *California Medicine*, Vol. 68, No. 4, April, 1948.

Office Gynecology

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SINCE half the population is female, every general practicing physician should have a working knowledge of the diagnosis and treatment of disorders peculiar to women. The subject receives a rather minor amount of time in most medical schools. According to Stander only 7.3 per cent of the total hours of instruction are devoted to this subject, as shown by a recent survey of undergraduate teaching in this country. Likewise, in the average rotating internship, gynecology receives little attention as an entity. Most of the cases seen are operative, and the intern gets little training in the minor problems. For these reasons, it seems justifiable to review some of the practical everyday problems of this important subject.

The approach to any woman's problems demands confidence in the physician. This is best gained by a gracious, patient, earnest attentiveness to her complaints, and a polite inquiry into her life history, and that of her family to bring out all the pertinent facts. Where the questions asked and answers given are intimate and confidential it is better to make a mental note and add these to the history later. Usually the best history can be obtained from the patient alone. Leading questions are best avoided, but it may be necessary to guide her back to essentials should she prove too loquacious.

Even though the complaint may seem strictly gynecological, it is a good plan to make a general physical examination, preferably in the presence of a female attendant. The height, weight, blood pressure, temperature, and pulse, if indicated, are recorded. By having the patient void prior to the examination, one obtains a specimen of urine for testing and fulfills the preparation for bimanual pelvic examination by having the bladder empty. In addition to the usual bimanual pelvic examination, there should be a rectal examination and inspection of the cervix and vaginal tract with the aid of a speculum.

VAGINAL DISORDERS

Vaginal discharge is a common complaint. Its origin may be from the urethra, Skene's glands, Bartholin's glands, the vagina, cervix, uterus, tubes, or from the bladder or rectum through fistulous tracts. The source is deter-

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mined and the material studied by hanging drop, stained smear, culture, or darkfield examination when indicated. A hanging drop of vaginal secretion may be studied microscopically for the presence of trichomonads or yeast fungus. Infestation of the vagina by the trichomonas vaginalis produces a profuse foamy yellowish discharge, while the monilia albicans produces a watery discharge and the vaginal walls are coated with patches of white cheesy material, which when removed leave an inflamed base. Gonorrheal discharges are thick, yellow, and creamy in the acute stage. Acute gonorrhea is best treated with rest, isolation, gentle saline douches, and penicillin in full therapeutic dosage. If any sensitivity to the drug is encountered, the coincident administration of benadryl may enable one to proceed. Yeast fungus vaginitis will respond to thorough painting of the genital tract with one per cent aqueous solution of gentian violet, repeated every three days until the symptoms subside. Trichomonas vaginalis vaginitis may be treated effectively with medicated powder. One swabs the vagina gently with cotton balls on a uterine forceps, then applies half an ounce of the powder with an insufflator, avoiding pressure if the patient is pregnant. The treatment is kept up by the patient at home by the insertion of tablets of the same material night and morning, even through the menstrual periods. A hanging drop is checked after each period for three cycles. When recurrence takes place it is well to have the husband's prostatic secretion examined as the source of reinfestation. Usually it is from the patient's bowel, so that proper cleansing habits after defecation are an important adjunct in clearing up this annoying disorder. Silver picrate, beta lactose, acetarsone or sulfonamides mixed with kaolin, and

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floraquin have been advocated. Karnaky, of Houston, who has written extensively on this subject likes floraquin, combined with vinegar, douches every few days, using about an ounce of vinegar to the quart of water. Simple vaginitis responds to the mildest of antiseptic douches such as the old pulvis mentholis compositis, although accompanying cervical disorders must be cleared up to avoid recurrence.

CERVICAL DISORDERS

Many lesions of the cervix may be treated in the office. Erosions are cauterized with the nasal tip cautery, electro-coagulated, or removed by conization, depending upon their extent and severity. Nabothian cysts are opened with the electric needle and evacuated. Mucus polyps are removed with the electric cutting loop and their bases fulgurated, or they may be excised and the bases cauterized with pure silver nitrate fused on an applicator. Any area, suspicious of malignancy may be likewise removed and subjected to pathologic study. Application of Gram's iodine solution will designate areas which do not stain as being the most likely areas to study by biopsy (Schiller's test). Deep lacerations of the cervix and frank malignancy may be diagnosed but their treatment requires hospitalization. Any indurated ulcer should have its surface secretion studied by the darkfield for *treponema pallida*. When cauterization or other operative procedures have been carried out it is well to apply a tampon medicated with boroglyceride or sulfa creme as an initial dressing, to be removed by the patient the following day.

UTERINE DISPLACEMENTS

Generally speaking retroversions of the congenital type or those acquired in early childhood from overfull bladders and strenuous play are asymptomatic. Those acquired later in life or following childbearing commonly give rise to distressing symptoms of low back pain, heaviness in the pelvis, persistent leucorrhea, constipation with hemorrhoid development, and menstrual disturbances. Reposition and the insertion of a properly fitting pessary often relieves these symptoms. A satisfactory method of doing this is to place the patient in a knee-chest position, insert a Sim's speculum, and with a cotton ball on a uterine dressing forceps gently push the bulging mass in the posterior fornix forward until the fornix appears smooth and round and the cervix, which at first pointed toward the symphysis pubis, now points toward the sacrum. An appropriate sized Smith pessary is then placed with its greater curve in the posterior fornix and its lesser curve behind the symphysis. The patient is then instructed to slide her knees backward and her

chest forward thus sinking to a prone horizontal position on her abdomen, at the same time straining to expel the air from her vagina. She is then instructed to empty her bladder at frequent intervals and to avoid heavy lifting or straining for at least the first week the pessary is being worn. At intervals of four to six weeks the pessary is removed, cleaned, polished, and replaced. If the symptoms subside but return on the removal of the pessary such a case is favorable for an operation of uterine suspension. In young women anticipating childbearing I try to avoid operative correction until they have born their desired number of children as it has been my experience that pregnancy, following uterine suspension, can be most uncomfortable with a myraid of distressingly painful sensations throughout. Moreover a fair per cent of uterine suspensions are broken down by subsequent parturition just as a nice gynoplastic result may be ruined by a later birth, and probably for the same reason, namely, that these individuals are possessed of a poor quality of connective tissue composed largely of white inelastic fibers which are unyielding and tear easily.

In elderly patients who have decensus or cystocele with distressing symptoms, I have had the best success with a light sponge rubber doughnut ring pessary of proper size. This must be periodically removed, cleansed, and replaced and the vaginal walls inspected for pressure or friction abrasions. If these are found, the pessary must be left out until they clear and later a smaller size used. It may be argued that these conditions should be treated surgically and cured. To this I quite agree, but it requires the patient's consent which is not always obtainable. Further, when the pessary is used palliatively until hospital admission can be obtained, the patient is often so agreeably relieved that she changes her mind about operation.

PREVENCEPTION

The premarital examination required by the laws of our State offers an unusual opportunity to be of service to the prospective mothers of our citizens. A careful examination may reveal rigid hymen, congenital anomalies, cervical erosions or other conditions that may require advice and treatment, as well as any existing venereal disease. Under local injection of novocaine, a rigid hymen may be incised. Through an infant size vaginal speculum cervical pathology may be treated. At least the abnormalities may be brought to the patient's attention with advice as to future treatment. I like to give Butterfield's booklet on "Marriage and Sexual Harmony" to these young women advising that they pass it on to their prospective husbands when they have looked it through. A little

wisdom at this time may save great difficulties later. For those who wish to be informed about control of conception, this is an ideal time to teach the appropriate method. The vaginal diaphragm and contraceptive jelly or creme continues to be the most reliable and acceptable method. For a small outlay any physician may have a set of fitting rings, an assortment of diaphragms and directors, and a supply of jelly and creme. This saves the prospective bride the possible further embarrassment of shopping around for such items. Proper fitting and instruction, with advice concerning follow-up checking is a part of the routine. I always like to add this admonition, "I hope you will lay aside these gadgets as soon as you are adjusted to married life and send for a baby, as that will seal your marriage and bind you and your husband together more securely than anything else." For those who may not be able to use this type of information because of religious beliefs or personal aversion, the Ogino-Knaus "safe period" instruction is to be recommended. In essence this involves abstinence during the time of greatest fertility, namely days ten to seventeen in women with a twenty-eight day cycle. It is now thought that ova, once shed, remain fresh and capable of being fertilized for only about a day, and that spermatazoa deposited in the female retain their viability for only about two days rather than a week or more as was formerly believed. Hence this method should be competent, providing the time of ovulation can be determined. However a great many failures have been reported.

THE STERILITY PROBLEM

At present we are finding the complaint of sterility is one of the commonest reasons for consulting a physician. The war kept husbands and wives apart, and others, who might have conceived, practiced contraception in order to aid with the war effort, or to avoid childbearing during such uncertain times. Now they are anxious to get their families started and are impatient with biological delays.

Although each case must be individualized, a general plan of attack is most helpful. The problem demands an approach from both the male and female angle. Whenever it is possible and the husband is willing I send him to the urologist for a complete check of his general health and physical condition with emphasis on a careful genital and reproductive survey, including studies of sperm count, motility and morphology. When this is not feasible because of his hours of work or for psychological reasons, I arrange to do the Huhner test at an appropriate time. The wife is instructed to elevate her hips on a firm pillow and to remain in a recumbent position for at least half

an hour after insemination. Then she reports as soon as possible, preferably within an hour without indulging in any preliminary cleansing operations. With a Graves speculum in place, one can obtain material from the vagina and from the cervical canal with appropriate aspiration devices and examine the same microscopically. If the cervical specimen is teeming with good motile sperm, the husband may be exonerated as a rule. If the vaginal specimen is full of sperm which are mostly dead and none are found in the cervical canal, it is well to require a preliminary alkaline douche and repeat the test. If no sperm are found it is well to insist that the husband be examined before anything further is done as it is illogical to continue one's efforts with the female unless the male has known potency.

The sterility study of the female starts with a complete history and physical examination, including studies of the blood, urine and basal metabolic rate. Obviously one would not pursue further attempts to overcome sterility in the presence of any condition which would seriously complicate pregnancy. Attention is first directed toward establishing a condition of good general health, and eliminating any foci of infection. Anemia is combatted with iron and hypothyroidism with thyroid extract. Any local infection or abnormality of the genital tract is given appropriate treatment. For example a simple nulliparous erosion of the cervix with its excessive production of mucus coating the external os simulates the use of a contraceptive jelly. The mucus adsorbes acid from the vaginal tract and thereby blocks the ingress of sperm like the Greeks at Thermopylae. An acquired retroversion may be corrected and a properly fitting pessary placed to hold the cervix in the seminal pool. A condition of physiological stenosis of the cervical canal may be alleviated by dilatation with graduated Hegar dilators, beginning with a number eleven French, and going up to number sixteen. This can be done without anesthesia although one should warn the patient that it will hurt her a little when the cervix is grasped with the tenaculum and when the dilators are inserted.

The next step is to determine tubal patency by the Rubin test which is best done shortly before the expected time of ovulation, in which case it may prove not only diagnostic but therapeutic as well. If the gas fails to pass at 200 mm. of mercury pressure, the tubes are presumed to be closed. However in the absence of any pelvic pathology or suggestive history the test is repeated the following month. If it is still negative one may arrange to instill iodized oil and have roentgenograms made to show the location of the stoppage. This procedure also has proven of therapeutic value in many hands.

Mechanical relief of obstructed tubes lies in the field of operative gynecology.

Where the cause seems to lie in hypoplasia of the uterus or acute anteversion one is justified in placing a stem pessary of proper size and suturing it fast. This is allowed to remain through two or three menstrual cycles but is promptly removed if a period is missed.

The possibility of anovulatory cycles may be ruled out by obtaining an endometrial biopsy during the last week of the cycle. This will show a definite secretory type of endometrium if ovulation has occurred and a corpus luteum body has formed. If this is impractical one may develop the technic of vaginal smears. If the epithelial cells are large and plump and show an acidophilic granular staining reaction, one may conclude that only the estrin effect is present, whereas, if the cells appear shrunken and crumpled and stain basophilic, the progestin effect is indicated.

Much has been said and written about the use of endocrine therapy for sterility, and certainly it has a place, but the cases must be individualized and no hard and fast rules can be laid down. Small doses of thyroid extract, one quarter or one half grain daily, even when there are no signs of hypothyroidism, seems to have rather universal approval. Traut believes that thyroid sensitizes the ovaries to the anterior pituitary hormones.

GYNECOLOGICAL ENDOCRINOLOGY

An appreciation of the physiology of the ductless glands is the first prerequisite in attacking any gynecologic endocrine problem. Someone has called the internally secreting glands a symphonic orchestra with the anterior pituitary as leader. If any member fails, lack of harmony prevails, others fail to get their cue, and soon there is discord throughout. If normal hormonal levels in the blood were known, and from a single blood specimen the variation from normal could be determined, one might quickly and exactly work out that individual's endocrine therapy. Unfortunately, this ideal is impractical and much of our endocrine therapy remains qualitatively and quantitatively empirical.

In diabetes mellitus, the internists have worked out rather exact dosages and diets to control nature's inadequate insulin production. For the sex endocrine glands this type of control is still in the process of fabrication. Potent substances are available and suggested dosage appears on the wrapper, but the clinical question is what to give, how to give it, how much to give, and when. Each patient requires individual treatment, and sufficient dosage must be used to produce the required physiological effect, keeping in mind the suppressive action which is

exerted on related gland activities. Generally speaking, endocrine therapy is only to be used when all organic disease has been eliminated, and when obesity, improper diet, lack of exercise, and improper hygienic living have been corrected.

The following outline of "Principle Actions and Uses of Sex Hormones", and comments on their potencies, is taken from Dr. Herbert F. Traut, professor of obstetrics and gynecology at the University of California, as presented before the Cincinnati Academy of Medicine, February 4, 1947.

I. ESTROGENS stimulate growth and development of the female genital tract and the mammary ducts; stimulate the growth and regeneration of the endometrium; stimulate uterine motility; have an inhibitory effect upon the anterior pituitary gland and upon ovulation; inhibit growth of the male genital tract. Useful in menopausal symptoms; gonorrheal vaginitis in children, senile vaginitis, kraurosis and pruritus vulvae, inhibition of lactation, atrophic rhinitis. Possibly useful in menstrual migraine, genital tract infantilism and dysmenorrhea associated with infantilism, missed abortion and uterine inertia, mastalgia, premenstrual tension. Doubtful indications: Amenorrhea, sterility, hypoplasia of breasts, nausea and vomiting of pregnancy, acne, hemophilia and frigidity, toxemias of pregnancy.

Comments regarding potency of estrogens: Estradiol is the true follicular hormone, while estrone and estriol are metabolic products. Estradiol is many times more potent than estrone by weight. The benzoate ester gives a prolonged effect, and the dipropionate ester results in a still greater prolongation. Similarly, a water suspension of estrone results in the intramuscular deposition of crystals and a prolongation of the effects. Estrone is 100 times as potent as estriol by injection, but nearly equal in potency when given orally. Weight for weight, ethinyl estradiol is the most potent estrogen for oral administration. With almost all estrogens, however, dosages may be adjusted to produce any desired effect but the frequency of administration depends upon the chemical structure, solute, and route of administration. Synthetic substitutes (e.g., stilbestrol) are more likely to produce toxic symptoms.

One I.U. equals 0.0001 mg. of estrone, so that 1 mg. equals 10,000 I.U. Since this relationship holds only for estrone, most other products are expressed by weight. One rat unit of estradiol benzoate equals about 10 I.U.

II. PROGESTIN brings about progestational proliferation of the endometrium (premenstrual secretory stage), may inhibit uterine motility, and will inhibit ovulation and menstruation.

Probably useful in habitual or threatened abortion and threatened premature labor. Of possible temporary benefit in dysmenorrhea, hemorrhage due to hyperplasia of the endometrium, and sterility due to deficient endometrial preparation.

One I.U. equals 1 mg. equals 1 rabbit unit (Corner-Allen), 5 mg. of anhydrohydroxyprogesterone by mouth is approximately equivalent to 10 mg. of progesterone by injection, although the former product differs in having weak estrogenic and androgenic activity. Pregnandiol is the inert end product of progesterone excreted in the urine.

III. ANDROGENS have a masculinizing influence and will correct evidence of castration in the male; will inhibit the growth of the female generative tract and breasts; and like the estrogens, will inhibit the anterior pituitary gland secretions. Also have actions similar to progestin. Useful in hypogonadism and castration in the males. Possibly useful in gynecology for menopausal symptoms, especially following castration for endometriosis, "functional" bleeding, dysmenorrhea, and inhibition of lactation, although such uses are still in experimental stage, and there is risk of producing virilism with large doses. One I.U. equals activity of 0.1 mg. of androsterone, which is a less active excretion product of testosterone. The crystalline esters of testosterone are measured by weight.

IV. A.P. GLAND EXTRACTS AND PREGNANT MARE SERUM: These gonadotropic substances have both a follicle stimulating and a follicle luteinizing action, but in various ratios. Pregnant mare serum is capable of stimulating ovulation, and of activating the resting ovary or testicle (e.g., causing ovulation) in animals. Questionable effects in women. Possible uses: Amenorrhea and oligomenorrhea; selected cases of sterility (both sexes) when due to primary deficiency of ovary or testicle. Probably more effective when given in combination with chorionic hormone.

V. CHORIONIC (A.P.L.) HORMONE is a gonadotropic substance elaborated by the chorionic tissue of the human placenta, and is excreted in the urine during pregnancy, forming the basis for the A-Z or Friedman tests. It has no action in the absence of the pituitary and is considered to be a synergist for the follicle stimulating hormone. It may stimulate the testis to secretory activity, but cannot activate the resting human ovary. It may at the most be able to luteinize persistent follicles. Uses: Practically limited to cryptorchidism and alleged stimulation of spermatogenesis; and in the female to treatment of "functional" uterine hemorrhage.

VI. LACTOGENIC HORMONE initiates lactation after "priming" of breasts with estrogens, and is concerned with corpus luteum maintenance. Probably useful in deficient lactation and in functional uterine bleeding.

There is no I.U. for the gonadotropic substance (anterior pituitary extracts) and they are standardized in rat units. One I.U. of pregnant mare serum hormone equals 0.25 mg. One I.U. of chorionic hormone equals 0.1 mg. One I.U. of prolactin equals 0.1 mg.

POSTOPERATIVE CARE

Many patients, especially from rural communities, depend upon their family doctor for postoperative care following hospitalization. It is desirable in such cases that he may have been present at or helped with the operation so as to be completely acquainted with what was done. If this is not possible, for any reason, the operating gynecologist can supply the proper information. In these days of inadequate hospital bed capacity, and of early ambulation, the major portion of convalescence is necessarily spent at home, with occasional trips to the near-by family physician's office for observation and treatment. In gynoplastic cases occasionally small granulomata occur along the suture lines which may be snipped off and their bases touched with silver nitrate. Where cotton or silk has been used in closing abdominal wounds it may be necessary to explore a persistent sinus with a crochet hook and remove the offending foreign body.

Patients may require continued treatment of anemia and general debility or the administration of hormones to counteract castration. Frequently the operation was only the first necessary step to take, and must be followed by a lengthy regime of gradually regaining strength, body tone, and nervous equilibrium. Insistence upon the proper amount of rest, the use of a well-fitted supporting garment, and the exhibition of iron and tonics with a good measure of cheerful encouragement gives the family doctor a large share of the job of getting the patient completely well.

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Reduction of Morbidity and Mortality in Lung Abscess By Early Surgical Intervention

ALVIN J. CARLSON, M.D.

THE conviction has been growing that lung abscess primarily is a surgical disease. In a very large proportion of the cases it is intractable to conservative medical treatment, and progresses to a complicated state in which death or irreversible changes with chronic invalidism are inevitable. Irreversible changes can be dealt with only by extirpation of the affected tissues, but they can be prevented by adequate surgical intervention early in the pathological process. Hence the theme of this paper is that the surgeon should be called in consultation at the very beginning of a case, to assure that the most appropriate procedure shall be carried out at the most favorable time. If he is to use his skill to the best advantage, the surgeon should be familiar with the case from its start.

The treatment of lung abscess has become a matter of teamwork. The internist, the bacteriologist, the roentgenologist, the bronchoscopist, and the surgeon constitute the team necessary to give adequate care to these patients. Unfortunately, the need for teamwork has not been sufficiently appreciated in the past, so that usually the surgeon inherits the case after complications have developed, and the patient has become weak, anemic, septic, and in poor condition to withstand the stress of surgery. It is no wonder, then, that the mortality charged to surgery has been high. Actually a large part of this mortality should be charged to conservative methods injudiciously prolonged.

As a basis for this thesis, let us examine a composite picture of the progress of this serious and disabling disease.

ETIOLOGY

The infection which causes pulmonary abscess may reach the lung by aspiration or it may be carried there by the blood, either as an embolus or in the course of a general septicemia.

Aspirated foreign substances are expelled with amazing facility by normal bronchi and bronchioles. Their walls contract, cilia sweep the offending material outward, and the cough reflex completes the defensive process. When any of these activities is absent, however, and aspirated material is retained, lung abscess results.

Infected secretions from the mouth or nasopharynx may be aspirated during any period of unconsciousness, whether produced by surgical

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anesthesia, coma from trauma or illness, drowning, epilepsy, drug poisoning, syncope, or even alcoholism. Most of the aspiration abscesses, however, follow tonsillectomy, dental extraction, or other operations in the nasopharynx. Pulmonary infection is particularly apt to occur if the patient is deeply anesthetized or under the influence of sedation, so that the cough reflex is inhibited. It also frequently follows aspiration of a foreign body which blocks a portion of the bronchial tree, prevents expulsion of infected material, and creates a condition favorable to growth of anaerobic bacteria.

Other causes of lung abscess are bronchial obstruction or stricture occurring in the course of pneumonia, emboli which reach the lungs from infected areas or operative sites in distant parts of the body, and general septicemia. The latter condition seems to produce abscesses entirely different from the other types. They usually are multiple and bilateral, and mortality is practically 100 per cent.

THE PATHOLOGICAL PROCESS

The initial lesion in lung abscess is an area of consolidation surrounded by an area of pneumonitis. Usually it is directly opposite a main bronchus in the periphery of a lobe. After necrosis and liquefaction occur, the abscess may evacuate through a bronchus, or it may rupture into the pleural cavity and produce empyema. The primary evacuation leaves an unvalled cavity in the soft tissue of the lung. If this cavity can be completely emptied and kept empty, it will collapse, and the lesion will heal. It is at this stage that medical treatment or surgical drainage are effective.

If curative measures fail, the patient's life may be terminated by rapidly spreading pneumonitis or gangrene of the lung. Otherwise the inflammatory process may extend to produce multiple abscesses, empyema, or pyopneumothorax. Surrounding blood vessels may be eroded, and

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hemorrhage may occur, or septic emboli may be carried to the brain or other parts of the body and cause secondary abscesses. If the patient lives on, an increasingly heavy wall of fibrous tissue is formed about the cavity which cannot be collapsed by any means, and this makes healing impossible. Multiple abscesses may develop, bronchiectasis may occur, or there may be periodic attacks of "pneumonia". At this stage the condition can be cured only by extirpation of the diseased tissue. If this is not done, the patient may live for years, a chronic lung invalid, and finally die as a result of his abscess or its complications, or he may die of intercurrent disease from which he has not the strength to recover.

DIAGNOSIS

The pathological evolution of the disease is paralleled by its clinical manifestations.

The earliest symptoms, sometimes masked by antecedent disease such as pneumonia, are persistent elevation of temperature with chills and a dry cough. Sometimes dyspnea and very often chest pain of a pleuritic type are present. At this stage the leukocyte count usually is high. After the abscess ruptures into a bronchus, the cough becomes productive of purulent sputum, usually in large amounts and often with a fetid odor. The diagnosis then is unmistakable. The temperature is prone to rise and fall daily as the abscess cavity fills or empties. The leukocyte count falls and in the later stages secondary anemia usually is present. The sedimentation rate is elevated throughout the course of the disease.

On physical examination, foul breath often is evident, together with dental caries and pyorrhea. Over the abscess area there is dullness to percussion, and rales may be audible. Breath sounds may be suppressed, or they may vary in quality from bronchovesicular, or tubular, to amphoric when the cavity is large, superficial, and empty. In some cases pulmonary signs are intermittent. Clubbing of fingers and toes is a characteristic sign, most frequent in chronic cases.

The X-ray at first shows an ill-defined area of pneumonitis, which may resemble pneumonia, atelectasis, or infarction, but which gradually becomes more sharply demarcated. Later, a cavity with fluid level becomes visible if there is bronchial communication. A fluid level, however, can be demonstrated in only about fifty per cent of the cases. When dense pneumonitis obscures the cavity, or it is filled with debris, a series of laminograms may reveal and localize the cavity. Stereoscopic roentgenograms made in all positions are helpful also in localization. This is further aided by bronchoscopy, as it is often possible to distinguish the bronchus from which pus is draining.

Lung abscess usually can be differentiated from tuberculosis by the clinical history, roent-

genograms, and sputum examination. Neoplasms, foreign bodies, and strictures may be complicated by abscess formation, and occasionally the first clinical sign of bronchogenic carcinoma will be abscess which results from blocking of the bronchus. Differentiation of tumors by X-ray may be difficult because some tumors cast shadows indistinguishable from abscess, but usually they can be seen on bronchoscopic examination. Infected cysts are somewhat easier to differentiate, even when they cast a shadow resembling abscess, because usually there is more than one cyst in the lung, while only one is infected. In contrast with the poorly defined outline of an abscess, usually a cyst is thin-walled and sharply outlined.

The long history is one point in differential diagnosis of bronchiectasis, and X-rays with lipiodol instillation usually will clinch the diagnosis. In acute lung abscess without complicating bronchiectasis, however, introduction of iodized oil has little diagnostic value, because rarely if ever will the oil enter the cavity. After communication with a bronchus has been established, the cavity may fill well.

Clinically, the chief distinction between interlobar empyema and lung abscess is that in the early stages of empyema the patient neither coughs nor brings up sputum. Should the empyema drain into a bronchus, there will be cough productive of purulent and usually odorless sputum. On the X-ray plate the empyema shows up as a well-demarcated shadow located in a fissure area.

BACTERIOLOGY

Many organisms—aerobes, anaerobes, and facultative anaerobes—have been isolated from lung abscesses. Anaerobic organisms of mouth infections usually are associated with aspiration abscesses, and produce a fetid odor. Most of the odorless type are caused by aerobic organisms, and apparently originate from pneumonia or embolism, but they may become contaminated with the anaerobes. Unfortunately, a knowledge of the bacterial flora is of little practical advantage in treatment of lung abscesses aside from the fact that certain organisms are susceptible and others are resistant to antibiotics or sulfonamides. In the great majority of cases these drugs have not been curative, although they are very helpful in preparing a patient for operation, and in controlling infection after operation. The reason for their limited usefulness, and also for the poor results with vaccines, may be that some of the organisms in this mixed infection are not susceptible; or it may be that niduses of the organisms are sequestered, so that the blood does not reach them in effective quantities. The course of a given case naturally is related both to the virulence of the infecting organisms and to the defenses of the body against them. Studies of the organisms

and of the patient's immune reactions, therefore, presumably might be helpful in prognosis and hence in determining the type of treatment.

COMPLICATIONS

Complications may occur at any stage of the disease, and should be searched for even at the onset. In fulminating cases, perforation into the pleural space, with consequent pyopneumothorax and bronchopleural fistula, may occur before there has been time to start treatment or even to make a diagnosis. Pulmonary complications, such as pneumonitis, pneumonia, bronchostenosis, atelectasis, hemorrhage, or interlobar empyema, may occur early or late as the result of extension of the disease within the lungs. In fact, the greatest cause of death is rapidly spreading pneumonitis, and the second greatest cause is pyopneumothorax. A very large proportion of the deaths occur within the first month.

Irreversible lung changes—multiple abscesses, bronchiectasis, or pulmonary fibrosis—of course are late manifestations. Massive pulmonary hemorrhage and gangrene of the lung may occur early in the disease, although apt to be delayed. Cerebral embolism, resulting in brain abscess or meningitis, is quite common, and usually fatal. Metastasis, however is not confined to the brain, for abscesses have been found in the abdominal wall, in the subphrenic region, in the kidneys, in the spleen, and even in the lower extremities. The infection may extend to neighboring organs, and cause suppurative mediastinitis, pericarditis, or myocarditis. It may also produce general septicemia.

CLASSIFICATION

Probably the most satisfactory classification of lung abscesses is based on the pathology: uncomplicated (simple) and complicated. This takes account of the fact that both treatment and prognosis differ according to whether or not complications have developed. Nevertheless, no classification is very helpful. Each patient must be considered in the light of his individual requirements, and we need always to remember that it is the patient who must be treated; not merely the disease.

TREATMENT

Because the great majority of patients who survive the acute phase eventually require surgical treatment, lung abscess is now regarded as primarily a surgical disease. It is considered good practice to make a short trial on medical and bronchoscopic treatment, with progress followed by frequent X-ray examinations. If the abscess does not resolve promptly, plans should be made for appropriate surgery. Since preparation for surgery is in all essentials identical with the best medical care, the period of conservative trial may be used as combined medical therapy and surgical preparation. A qualified lung sur-

geon, therefore, should be in attendance from the onset, so that precious time may not be lost between medical and surgical treatment.

The combined treatment should consist of bed rest with high-caloric, high-protein, high-vitamin diet, supplemented with vitamin preparations and minerals, and if necessary with injections of amino acids and transfusions of whole blood. Every effort should be made to build up the patient's general health. Frequent postural drainage is important if there is a patent communication between the abscess and the bronchial tree. The secretions can be thinned out by use of iodides, guaiacol, or inhalations of steam. Sulfonamides and penicillin are used quite extensively, both parenterally and by inhalation. They are helpful in clearing up the area of pneumonitis, but in most cases have little effect on the abscess itself. Immediately before and after operation they are valuable to combat any postoperative infection. Postural drainage should be supplemented by bronchoscopic aspiration of secretions, dilation of bronchial stenosis, shrinking of swollen mucosa, and removal of foreign bodies, mucus plugs, or obstructing granulation tissue. A great deal can be done by combined postural and bronchoscopic drainage to clear up the abscess at least temporarily and so reduce the operative risk. Too often, however, because the patient appears to improve clinically after each bronchoscopy, the procedure is continued beyond the uncomplicated stage, and this must be guarded against.

If, under such a regime, the abscess fails to show unmistakable signs of resolution, surgical intervention should be prompt. In single, uncomplicated abscesses, dependent surgical drainage in one or two stages usually will produce collapse of the tissues surrounding the cavity and healing. Once complications have set in, however, drainage is only palliative. This is true for several reasons: In complicated single abscesses the fibrous wall resists collapse which is essential for healing. In cases in which multiple abscesses, bronchiectasis, or chronic pneumonitis have developed, drainage is never complete. Thus, after the wound has healed, a nidus of infection remains which re-establishes the usual course of complications. Total removal of the diseased tissue gives the only hope of permanent relief. Since this is known to be the case, nothing is to be gained by temporizing unless the patient is in too poor condition to tolerate surgery.

Operations for the purpose of collapsing the lung not only are ineffective in non-tuberculous lung abscess, but actually may spread the infection. Accordingly, pneumothorax, interruption of the phrenic nerve, and thoracoplasty are no longer done for this condition.

Segmental pneumonectomy, lobectomy, bilobectomy, or total pneumonectomy are today re-

garded as the only operations capable of curing this intractable disease in the complicated stage. Morbidity and mortality, however, have been high, primarily because the patients, owing to their chronic infection, are in very poor physical condition. Too, the nature of the disease causes pleural adhesions which may be difficult if not impossible to separate, and in the attempt to separate them the abscess may be entered, with resultant empyema. The hilar structures, which ordinarily should be treated by individual ligation, may be so adherent or so obscured by hemorrhagic lymph nodes as to make this procedure too hazardous. The tourniquet method, which is the only alternative, is all too frequently followed by fistula and empyema.

Thus the surgeon is confronted with a choice between (1) the most difficult type of pulmonary resection, with a relatively high morbidity and mortality but a high percentage of cures in the patients who survive, and (2) a simpler surgical procedure, with a lower mortality rate, which is only palliative and will leave the patient a chronic pulmonary invalid. Believe me, the choice is a difficult one.

While radical lung surgery undoubtedly is serious, there is reason to believe that the morbidity and mortality rate can be reduced if the proper operation is done early in the course of the disease, with adequate preparation and post-operative care. The best treatment for chronic, complicated abscess is prophylaxis, which, in the majority of cases, means early surgical intervention during the acute or uncomplicated stage.

PROGNOSIS

Because the statistics published in the literature on lung abscess are not on a common basis, it is possible only to approximate the percentage of cures and of mortality. The status seems to be about as follows:

- (1) Approximately 20 per cent of lung abscesses heal spontaneously.
- (2) Perhaps another 30 per cent heal under medical and bronchoscopic treatment.
- (3) Surgical drainage, if done before complications develop, will result in healing of approximately 30 to 35 per cent in addition. Mortality in well-chosen cases may be as low as 3 per cent, but usually is somewhat higher.
- (4) If primary surgical drainage fails, there is little use to repeat this procedure. Secondary drainage seldom is successful.
- (5) Complicated cases can be healed only by total extirpation of the diseased and degenerated tissues. The mortality is high, ranging up to 45 per cent, but almost 100 per cent of the survivors are cured.
- (6) A certain percentage of patients will die no matter what is done. A further percentage will remain alive, but with continuing evidence

of the disease, living under the constant threat of recurrence. Doubtless a large proportion of these eventually die of the disease, although statistics on this subject are lacking. It would be a real service if institutions which have had large groups of cases would make twenty- or thirty-year follow up studies.

(7) The mortality in surgically treated cases has been high because the surgeon inherits the medical failures, and the patients reach him in very bad condition. Mortality actually attributable to surgery is not over 2 to 4 per cent. Most of the patients who die under surgical treatment would die without it, and a good number of those who die without it could be saved by prompt, appropriate, and competent surgery.

Enuresis, A Common Sense Treatment

The parents must be instructed in the elementary fact that the voluntary control of the act of urination during sleep arrives at a later age than during waking hours. Their failure to act in terms of this single bit of knowledge causes them to heap shame, their resentment, physical punishment, disagreeable dietary, and medical and surgical treatment on a perfectly normal child.

Previous articles in pediatric and psychologic journals have mentioned the fact that enuresis is associated with evidence of emotional instability, social immaturity, maladjustment to home and school situation, and psychoneurotic symptoms in a variety of combinations. This explains why so frequently the following various types of treatment have failed; medical or surgical care, physical punishment, start-stop training, alarm clocks, gold star charts, rewards, lost privileges, no fluids after 4 p. m., salty foods at bedtime (even caviar has been advocated!) and a host of others.

Since urination is a normal voluntary function, there should not be any discussion of the problem with the child. It is difficult and at times impossible to reason with a preschool child. By seemingly ignoring the problem in his presence an argument is usually avoided. The enuretic child probably analyzes the situation as follows: "my father and mother are bigger than I am. They can boss me and make me do lots of things but they can't make me stop wetting my bed if I don't want to, because I am the boss of that job!"

It is the duty of the physician to instill confidence in the child so that he will be able to overcome the condition. His cooperation is usually assured by convincing him that he is big enough, strong enough, bright enough, and willing to be dry.—Norman W. Clein, M. D., Seattle, Wash. Northwest Medicine Vol. 47, No. 4, April, 1948.

The Syndrome of Guillain-Barre: A Case Report

J. CHANDLER SMITH, M. D.

A 50-year old white male entered the hospital complaining of weakness of the extremities, inability to close the eyes, and respiratory distress.

Two weeks before admission the patient experienced pain in the muscles of the neck and a tingling sensation of the fingers. On the next day numbness and tingling of the toes were noted and this was followed by weakness of the extremities which became so great that the patient was bedfast four days after the onset of the illness. Three days later difficulty in swallowing solid and liquid food was experienced. On the next day weakness of the entire face became so marked that the patient was unable to close his eyes. Twelve days after the onset of the illness the patient experienced moderate respiratory distress, and weakness of the arms and legs became extreme.

The past medical history was insignificant except that there had been no recent upper respiratory infection or other illness.

On admission the temperature was 37.9 degrees C., the pulse 100 and the respirations 39. The blood pressure was 110/55. Physical examination revealed a well-developed, obese, acutely ill white male in moderate respiratory distress. The conjunctivae were hyperemic and the pupillary reactions were normal. There was a symmetrical weakness of the entire facial musculature. The pharynx was hyperemic and the soft palate responded weakly to stimulation. Examination of the heart revealed a regular tachycardia. Respiratory movements were shallow and rapid, and rhonchi were audible over the posterior pulmonary bases. The abdomen was not remarkable. There was extreme weakness of the arms and legs. All deep reflexes and the abdominal and cremasteric reflexes were absent. There was reduced pain and temperature sensation over the dorsum of both feet. No pathologic reflexes were elicited.

LABORATORY EXAMINATIONS

The hemoglobin was 20.0 gm. and the erythrocyte count was 7,000,000 per cu. mm. There were 17,800 leucocytes per cu. mm. and differential count of 100 cells revealed 81 polymorphonuclear cells, 17 lymphocytes, two mononuclear cells, and one unclassified cell. Urinalysis was not remarkable. The spinal fluid was clear, under normal pressure, and examination revealed two cells per cu. mm. and 180 mg. of protein per 100 cc. The Kline test was negative.

The hospital course was characterized by increasing respiratory distress and the patient was placed in a respirator. He became irrational and cyanotic. The temperature rose to 39.5 degrees C. and the patient died in respiratory failure on the twentieth hospital day.

AUTOPSY (17063)

At autopsy the central nervous system revealed few gross pathologic changes. The brain weighed 1,575 gm. The surface was covered by intact transparent leptomeninges. The normal pattern of gyri was present although the convolutions were somewhat wide and flattened.

Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at Cleveland City Hospital as the 38th of a series of cases to be published under the heading "Case Records Presenting Clinical Problems."

Coronal sections made at 1 cm. intervals throughout the brain revealed an average gross structure and ventricles of usual size lined by smooth glistening ependyma. The medulla, pons, cerebellum, and spinal cord were not remarkable on gross examination.

The other pertinent gross pathologic diagnoses included moderate hypertrophy of the heart (480 gm.), chronic nondeforming endocarditis of the mitral and aortic valves and Laennec's cirrhosis. There was bronchopneumonia of the right lung and lower lobe of the left lung.

MICROSCOPIC EXAMINATION

There was acute passive hyperemia of the cerebral cortex and medulla. Infrequent small hemorrhages were present throughout the cortex. Focal perivascular hemorrhages were found in the region of the anterior horn cells of the spinal cord. The right facial nerve showed degeneration of axis cylinders, demyelination and fragmentation of the myelin sheaths, and there was focal demyelination of the left facial nerve. The left phrenic nerve and both vagus nerves were not remarkable. There was slight perineural round cell infiltration of the cervical and lumbar nerve roots.

COMMENT

This case illustrates a typical example of the syndrome of Guillain-Barré, a self-limited sporadic disease occurring usually between the ages of 20 and 50 with equal frequency in the sexes and characterized by a progressive ascending paralysis, albumino-cytologic dissociation of the spinal fluid, and a tendency to complete recovery. The syndrome was first described in 1892 by Osler under the term, "acute febrile polyneuritis."¹ Guillain, Barré, and Strohl first reported in 1916 the low cell count and high protein of the spinal fluid (albumino-cytologic dissociation).² Many cases have now been reported.³

The etiology of the syndrome remains unknown. A virus infection is presumed by most writers but no organism has been cultured from the central nervous system or viscera of patients with the syndrome and transfer of the disease to a laboratory animal has not been accomplished.² Various illnesses have preceded the attack, especially upper respiratory infections.^{3, 4, 6}

The essential pathologic change concerns chiefly the peripheral and cranial nerves and consists of degeneration and demyelination without prominent signs of inflammation. Changes in the brain and spinal cord are usually slight.^{2, 3} Gross examination reveals moderate edema of the brain, spinal cord and peripheral nerves with slight hyperemia of the overlying meninges. Upon microscopic examination of the peripheral nerves, edema, hyperemia, swelling of the myelin sheaths, fragmentation and

dissolution of the axis cylinders, and slight focal infiltration of lymphocytes and plasma cells are found. The anterior horn cells of the spinal cord are reported to show widening of the perineuronal spaces, nuclear chromatolysis, and cytoplasmic vacuolization.² Sabin and Aring⁷ report visceral changes consisting of acute passive hyperemia of the liver, heart, kidneys, and spleen with slight round cell infiltration of each. In a few cases scant or no changes are discernible in the nervous system.²

The characteristic finding upon which the diagnosis is made and by which the complex is regarded as a clinical entity is the albumino-cytologic dissociation. In most cases there is an acellular hyperalbuminosis varying from 70 to 800 mg. per 100 cc. The spinal fluid cell count is usually normal although up to 25 lymphocytes may be present. A leucocytosis of 10,000 to 15,000 cells per cu. mm. with a slight neutrophilia is common.

The onset of neurologic manifestations generally follows an upper respiratory infection, often by a latent period of one to three weeks. The earliest neurologic symptoms are usually sensory and consist of pain and tenderness in the legs and back and paresthesias of the hands and feet. It is characteristic that the sensory disturbances tend to be marked in the distal portion of the extremities and diminish in severity proximally. Impairment of vibratory sense and diminished perception of pain and light touch may be present. Motor changes may appear suddenly or insidiously at any time after the onset of sensory symptoms.² These changes usually consist of a flaccid paralysis progressing to a quadriplegia that tends to be bilateral, symmetrical and often more striking in the proximal than the distal portions of the extremities. The degree of paresis varies from slight muscular weakness to complete loss of voluntary movement. Cranial nerve involvement is frequent and the common infranuclear seventh nerve paresis is manifested by weakness of the muscles of the entire face. Sphincter involvement is limited to the moribund and tendon reflexes are usually diminished or absent. Pathological reflexes are rarely elicited. Atrophy of muscle segments and involvement of trunk, intercostal muscles and diaphragm renders the outlook exceedingly grave.

The syndrome in most instances lasts two to three weeks and is followed by a prolonged convalescence during which function tends to return in the same order in which it was lost. Occasionally weakness or paralysis persists. Death is most often due to respiratory paralysis and usually occurs during the first two weeks. The mortality of 126 reported hospital cases as reviewed by Fox and O'Connor⁸ is approximately 20 per cent. This figure is surely high as the

mild nature of many cases does not lead to hospitalization. Recurrences have not been reported.²

The diagnosis is made when a patient has a flaccid paralysis of progressive nature and a significant elevation of protein with normal cell count of spinal fluid. The differential diagnosis includes acute anterior poliomyelitis, post-diphtheritic polyneuritis, spinal cord tumor, alcoholic neuritis, and the neuritis of vitamin deficiency. Acute anterior poliomyelitis occurs chiefly in children in seasonal incidence and epidemic form. There is no latent period between the frequent upper respiratory infection and the onset of neurologic symptoms. The paralysis is rarely ascending, the spinal fluid reveals a pleocytosis, cranial nerve pareses are rare and residual paralyses common. Postdiphtheritic polyneuritis may be difficult to distinguish because motor and sensory nerve impairment may be marked and there may be elevated spinal fluid protein. However, recent history of the disease with identification of *C. diphtheriae* and paralysis of the eye aid in differentiation. Tumor of the spinal cord is often not preceded by respiratory infection and frequently may be localized by careful neurologic examination. Alcoholic and vitamin deficiency neuritis are painful and show no albumino-cytologic dissociation of the spinal fluid.⁹

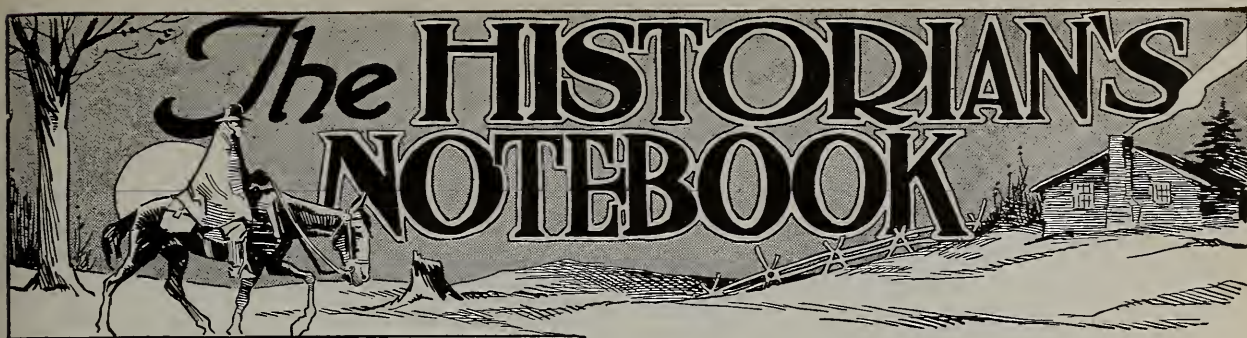
There is no specific therapy and treatment is necessarily symptomatic and supportive. Physiotherapy, hydrotherapy, and massage stimulate and retain muscle tone. Treatment is also directed at any accompanying diseases.

SUMMARY

A case of Guillain-Barré syndrome is presented which is typical in that the illness was heralded by sensory symptoms followed shortly by a progressive paralysis of the extremities and a facial diplegia. There was albumino-cytologic dissociation of the spinal fluid. Autopsy examination revealed demyelination and degeneration of the facial nerves and slight round cell infiltration of the cervical and lumbar nerve roots.

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Ohio Medicine in the Gay Nineties

Part II—1890-1945

JONATHAN FORMAN, M. D.

(Continued from May Issue)

AMONG the great achievements in the therapy which took place during the era under discussion, those of bacteriology stand out as the dominant ones. No sooner had it been established that bacteria really caused disease and death resulted from certain structural changes which could be demonstrated at the necropsy either in the gross material or under the microscope with the new method of fixing and staining tissues, than the cults in medicine were doomed, for now there had come into being "Scientific Medicine."

Medical men in their enthusiasm called themselves "scientists" failing to realize that they only applied to the sick more or less empirically what the scientist taught them about physiology, bacteriology, and physiological chemistry. For the same reasons the physicians of the last generation forgot to think about what the ancients had pondered well, i.e., that man's reaction to his food, his weather, and his soil were more often than not the ultimate causes of disease and the determinate factors in disease.

BACTERIOLOGY

But in the early '90's, the hope among medical men was that specific methods of treatment and preventive procedures based upon the findings of the bacteriologist would become available for practically every disease. But as the years went by they found that immunity was often only relative and resistance to disease—even bacterial diseases—depended upon such a great number of other factors that the absolute specific measure which proved perfectly successful in the experimental laboratory were only of relative value.

Furthermore, one disease after another proved not to be of bacterial origin at all and was turned over to the physiologic chemist for solution.

There is no better illustration of the effect of this type of thinking than the arrangement of Osler's "Principles and Practices of Medicine" which appeared in 1892. After an advance of the times as organization plan of this text on medicine was in 1892, future research in immunology, medical physics, and chemistry proved it to be sound. The link between endocrine disorders and nutritional deficiencies has become clear; the independent significance of nutritional deficiencies has been emphasized by the unraveling of the nature of scurvy, beri-beri, pellagra, and other specific deficiencies. Now we are on the threshold of discovering that physical defects and chronic illnesses are the results of a lifetime (and sometimes two) of bad eating; that the major cause among the ultimate causes of sickness is *malnutrition*. Clinical neurology develops along with other parts of the field of Medicine because diseases of the nervous system were likewise clinical entities with a sound anatomical basis. Such was not true in the field of psychiatry. It was not until late in this era that it became apparent that in psychiatry the physician is not dealing with clinical entities but with groups of symptoms. In some the underlying cause is known, such as the syphilitic psychoses, endocrine deficiencies and imbalances, faulty nutrition, and chronic poisonings; but in many the cause awaits discovery. It would seem that we waste too much time recording and pondering upon the vagaries

of a sick mind and not enough is spent on the feeding of our psychotic patients with the best possible diet in the cleanest of surroundings.

Pediatrics from 1890 to 1945 made tremendous strides. It has always had the attention of the best minds in Medicine for here is offered the greatest opportunity for humanitarian service to society and the best chances of effecting a cure.

ANTITOXIN

It was in 1891 that von Behring announced the production of a curative antitoxin for the bacillus diphtheria and at the same time it became possible to identify diphtheria as a specific infection and to differentiate it from scarlatina and other disease complexes.

As has been noted it was also in 1891 that Oskar Medin reported his observations over a ten-year period of anterior poliomyelitis which had assumed epidemic proportion in his native Sweden and these formed the background for the modern recognition of the disease.

In 1882, the tubercle bacillus had been discovered; by 1889, Henoch had become uneasy about milk from tuberculous cows; and George Küss established (1898) the essential pathology of the aerogenous type of infection. It was also in the first 20 years of this era (1880-1900) that the various Pasteur Institutes were established in this country and our people came to believe in and demand the "Pasteur treatment" for hydrophobia. At the end of this period, Dr. J. McI. Phillips began to give such treatments here in Columbus to be followed shortly by Dr. Ernest Scott, Dr. E. G. Horton, and Dr. E. F. McCampbell, uniting to give a similar service for several years. Beginning in the Fall of 1911 it was one of my daily tasks to help in the preparation and distribution of the treatment material.

METABOLIC DISEASES

When we leave the field of infectious diseases and entities and move over into that of the metabolic and Nutritive Disorders, we find equally important progress made. The chemists have become physiologists as had the physicists. These new chemical physiologists gave many new facts to apply to problems of growth and development of our children. Scurvy had been identified before but its real nature and the importance of vitamin C for its prevention came in this era. Cod liver oil as a protection against ricketts supplemented all other forms of medication.

PASTEUR

While our people were busy fighting the Civil War, Pasteur published his review of the question of spontaneous generation and pointed out that putrefaction of previously sterilized meat

infusions is due to the admissions of bacterial agents from the air. This review happened to be read by Joseph Lister who seized up its idea as an explanation of the putrefactive processes seen in surgical practice. Lister figured that if he could in some way sterilize the wound and keep the germ laden air away from it that putrefaction could not happen. After first trying alcohol and zinc chloride, he settled on a carbolic acid spray, although it was less effective. Many persons treated according to his idea died of phenol poisoning. While the antiseptic method was useful for new or uninfected wounds, it proved useless in the face of established infection and pus was still often looked upon as laudable. Lister did focus attention of the surgical world upon infection as their major problem. Meantime, while the controversy raged around him. Koch brought forward incontrovertible proof of the bacterial nature of surgical sepsis. In 1886, Ernest von Bergman introduced steam sterilization into surgery and out of this grew the aseptic period to supplement the antiseptic technique of Lister.

ENDOSCOPES

The next improvements in the field of surgery were all technical as one would expect from our age of technical inventions. Absorbable sutures, elastic bandages, plaster of paris, rolled bandages, and endoscopic instruments of a sort were available to the surgeon when this era began. Its first great contribution was the X-ray (1895).

X-RAY

Then came the discovery of X-ray by Roentgen in 1897 and of radium by Pierre and Marie Curie in 1898. Much of the rapid progress in both medicine and surgery has been due to these discoveries which deserve to be recorded among the greatest contributions of all time to the advancement of the healing arts.

From here on there were innovations in science applicable to medical and surgical techniques. As time goes on, our group will arrange these and bring the story of each as it affected medicine in Ohio to the pages of *The Ohio Historical Quarterly*. Suffice it to say now that almost every year brings forward a new discovery of permanent value which prolongs the life or ameliorates the suffering of humanity.

Modern surgery owes a debt of thanks for the studies from which evolved the four compatible blood groups discovered just prior to World War I. Both operability and morbidity, as well as lowered mortality, have received a marvelous impetus because of the use of whole human fresh blood in the aged and the substandard risk.

(To Be Continued)

Facts and Impressions Regarding the National Health Assembly of 1948 Held in Washington, D. C., May 1-4

By CHARLES S. NELSON, Executive Secretary
Ohio State Medical Association

ON authorization of The Council of the Ohio State Medical Association, the writer attended the National Health Assembly of 1948, May 1-4, as a reporter for *The Ohio State Medical Journal*.

In that capacity he was accorded the privilege of attending all sessions of the assembly which was called by Federal Security Administrator Oscar W. Ewing. Approximately 1,000 delegates and observers were in attendance. Almost every agency or group concerned even remotely with health was represented.

The writer was unable to attend all sessions of the 14 sections and half dozen general sessions. However, an excellent job of supplying reporters, delegates, and observers with reviews of the proceedings, prepared by the section chairmen, was done.

NO FORMAL VOTING

There was no formal voting on resolutions and recommendations, thus the delegates were not necessarily committed officially to any view point. The discussions were kept on an informal basis in most instances. At the end of each session, the section steering committee prepared a review of the questions discussed and points made by the delegates. These were in the main factual reports, covering the pros and cons presented by the discussants. Areas of controversy were specified. Where the delegates could agree, the reports so stated.

Following are some general impressions of the proceedings of the assembly gained by the writer through personal observation or from the reports issued by the section officials:

SOME IMPRESSIONS

1. The assembly was conducted efficiently. Efforts were made to handle the program and the reports in a fair and impartial manner. Delegates were given ample time to express their views and present their problems. Delegates in general were sincere and hard-working—in most instances well-informed. The section chairmen tried hard to keep the discussions in constructive channels and to prevent personality clashes.

2. There was little, if any, reference to partisan politics—in fact politics in general—or to specific legislative proposals. Of course, it may be assumed that both proponents and opponents of controversial legislative measures will make use of any point brought out during the assembly which they believe will aid their

cause. The few instances of propagandizing which occurred should be regarded as minor phases of the assembly and not typical of the over-all character of the conference.

CONSTRUCTIVE WORK DONE

3. Constructive work was done. Many misunderstandings between groups were eliminated or reduced to a minimum. Agreements were reached on policies and methods relating to the attacks which should be made to solve many existing health problems.

4. Most of the delegates, it is believed, subscribed to the theory that the solutions for many of these problems can, and should be worked out in local communities, but at the same time concede that there is a place for state and national planning and action within reasonable limits.

5. There was rather general agreement that the consumers and the producers of health and medical services can, and should, reach an understanding in many fields of health activity.

ECONOMIC AND SOCIAL PROBLEMS

6. Evidence presented revealed that health problems cannot be separated from economic and social problems; that there must be vigorous attacks on all three fronts.

7. Many present expressed the view that local and state governments, even the Federal Government, will have to bear in the future a heavier share of the costs of financing health services, medical services for certain groups, medical education, medical research, etc., than in the past. Most of the delegates, it is believed, are of the opinion that Federal aid should be afforded in most instances only as supplemental assistance and that administrative responsibilities should remain in the hands of local and state groups and agencies so far as possible.

COMMUNITY PLANNING AND ACTION

8. Community planning and cooperation, with all lay and professional groups participating are essential to insure the success of health and medical problems. This point was stressed again and again.

9. It was emphasized repeatedly that the people, the professions and governmental agencies can, and should work together but that none of the three should infringe on the recognized rights, responsibilities, and functions of the other two.

10. Most of the sections pointed out that

one of the most critical problems is that of shortage of trained and skilled professional and technical personnel; this problem demands immediate attention; discrimination against minority groups must be abolished.

11. More attention, planning, and action must be devoted to finding the solution for the health and medical problems of those residing in rural areas—a question of real concern to residents of urban areas also.

PREPAYMENT PRINCIPLE ENDORSED

12. There was general agreement that prepayment, i.e., insurance, is the best way of financing the costs of medical and hospital care but there was sharp disagreement as to whether voluntary or compulsory methods should be adopted.

13. In addresses to the assembly, President Truman and Mr. Ewing definitely declared that they favor some form of compulsory, government-administered health insurance.

14. There was overwhelming sentiment in favor of the United States affiliating with the World Health Organization.

A.M.A. REPRESENTATIVES PRAISED

15. Representatives of the American Medical Association and the various state and local medical societies, and other physicians attending as individuals or representing other organizations, with a few exceptions, made valuable contributions to the assembly and won the respect and gratitude of the majority of the delegates. The exceptions were a handful of physicians and others who were spokesmen for radical groups which are notorious for their socialistic leanings on all public issues.

16. In all probability no new converts were won by either side in the feud over the Truman health program. On the other hand, a better understanding was developed between many lay and professional groups whose chief motive is to find sound and practical ways of establishing a better health program in all parts of the country.

Space will not permit a detailed account of the addresses and informal discussions made at the section and general sessions nor a complete review of the transactions of the 14 sections.

However, an attempt will be made to present the high spots of the final reports issued by all section chairmen.

SECTION ON MEDICAL CARE

Section No. 8, "Medical Care," drew the largest attendance of any of the sections. As might be expected, the discussions were heated at times. Despite militant efforts on the part of Michael Davis, Boas, and their followers to force the

section delegates to approve the principle of compulsory health insurance, the steering committee reported disagreement within the section on this question and let it rest at that. A magnificent job of presiding, under trying circumstances, was done by Dr. Hugh Leavell, Harvard School of Public Health.

The following excerpts from the tentative final report on the section transactions reveal the scope of the section's work and the areas of agreement and disagreement among the delegates:

GENERAL CONCLUSIONS

1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical, mental and social health should be available to all without regard to race, color, creed, residence or economic status.

2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test."

3. Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional

a. services to persons or groups for whom special public responsibility is acknowledged and

b. services not available under prepayment or insurance.

4. Voluntary prepayment group health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means.

5. The people have the right to establish voluntary insurance plans on a cooperative basis and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications), now existing in a number of States, should be removed.

6. High standards of service, efficient administration and reasonable costs require:

a. Coordination of the services of physicians, hospitals, and other health agencies in all phases of prevention, diagnosis, and treatment;

b. Effective cooperation between the providers and the consumers of such services.

7. A medical care program by itself will not solve the health problems of the Nation. It must be coordinated with all efforts directed toward providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation and such other measures as will correct conditions that adversely affect the physical, mental, and social health of the people.

8. There are areas on which the Planning Committee is not yet prepared to report. In the meetings of the Medical Care Section, differing views were expressed as to the method of effectuating the principle of prepayment or insurance. Some believe it can be achieved through voluntary plans. Others believe that a national health insurance plan is necessary.

The following conclusions were approved by the section relative to points to be measured in determining the effectiveness of prepayment plans in meeting the medical care needs of the people:

POINTS ON EFFECTIVENESS

1. The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury.

2. The proportion a plan covers of the population of its areas—local, state, or national, as the case may be. (Cost in relation to ability to pay, restrictions on enrollment imposed by actuarial considerations, income level, age, conditions of employment, means of securing enrollment and collecting premiums.)

3. The degree to which a plan makes use of and encourages the development of a high quality of medical care for its subscribers. (Standards of personnel and facilities; organization of services; emphasis on prevention of disease, promotion of health, health education.)

4. The degree to which freedom and willingness to experiment with methods of payment and operation are encouraged in a plan.

5. The degree to which a plan succeeds in arranging amounts and methods of payment and conditions of participation that are satisfactory to physicians, hospitals, and others serving the plan's subscribers.

6. The extent to which efficiency and economy in the operation of a plan are achieved and encouraged by its basic policies and its administrative techniques.

7. The extent to which the individuals or board who carry the ultimate responsibility for a plan represent the interest of those entitled to service and those who are paying the cost, as well as of the physicians, hospitals, or others who are providing the services.

HOW TO IMPROVE THEM

The following principles for the improvement of voluntary prepayment plans were listed:

1. There should be the freest opportunity for full cooperation among the providers and consumers of service in the establishment and the administration of medical care plans, provided that full control of the practice of medicine in the program must remain with doctors.

2. The medical care section strongly urges the importance of joint conferences at the earliest possible date among representatives of the American Medical Association and of groups representing the consumers of medical care and services to study the question of the establishment and administration of medical care plans,

SECTION ON RURAL HEALTH

Joseph W. Fichter, Columbus, Ohio, Master of the Ohio State Grange, was chairman of the Section on Rural Health, one of the most important of the assembly.

In his opening remarks to the section delegates, Mr. Fichter made the following observations:

"It is significant that one section of the National Health Assembly is devoted to rural health. This is a recognition of the fact that the people

residing in the farm areas of the nation are at a great disadvantage in their attempts to obtain medical care and health facilities. Farm people are no longer satisfied with being treated as country cousins in health matters or in any other affairs.

"Although farmers render the service that is most essential to society, their relatively low share of the national income places them at a great disadvantage in maintaining living conditions which are conducive to good health.

"In these so-called good times, the farmers, who constitute one-fifth of our population, are receiving only one-ninth of the national income.

"Farmers are discussing this situation in their organizations, and they are determined to find ways of removing the disadvantages which handicap them in their quest for a healthful living environment."

The reports on the section discussions brought out the following points:

PREPAYMENT PLANS

1. Although there was considerable disagreement within the section over the question of national compulsory health insurance, substantial progress was made in elimination of misunderstandings between members of the medical profession and representatives of cooperative medical care associations. There was agreement on the prepayment principle.

The following two points received the approval of the majority: (a) The enactment of enabling legislation in each state, such as that recently passed in Wisconsin, establishing the right of cooperative groups to contract with doctors for their professional services; (b) The desire of the medical profession is only to insure that the terms of the contract with the doctor be such as to provide for the highest type of medical service to those concerned.

RURAL NEEDS

2. As a general goal: Comprehensive medical care, health education, and preventive medicine adapted to the needs of rural people should be available to all without regard to economic or social status.

3. To achieve the above goal, attempts should be made first by people of local communities and counties; after they have done everything possible for themselves, state and Federal equalization funds should be sought.

4. The problem of encouraging medical school graduates to locate in the country is real and acute. It was agreed that state governments and other agencies should provide scholarships, fellowships, and loan funds so that more rural youth will have an opportunity to study medicine; rural doctors should be provided with the best of modern facilities and with opportunities for group practice, and for frequent postgraduate training.

ADDITIONAL SUGGESTIONS

5. Among miscellaneous suggestions which were offered, the following received rather gen-

eral approval: Governmental officials should be free to present factual and technical information at local "workshops" but should not indulge in spreading propaganda for any particular type of health insurance. There should be farm-to-market roads, adequate power, electricity, and telephones available in rural communities. Subjects of nutrition, education, and soil conservation should be emphasized. Farm income should be stabilized. All families able should pay for medical care. Rural families should be supplied with decent water supplies and sanitation facilities. An adequate number of trained nurses is needed. Education in hospital construction and utilization should be stressed. Adequate coverage of all rural areas with adequately staffed county or multi-county health departments is essential. Preventive medicine should be stressed. Each state should have a health council, with local affiliates.

SECTION ON COMMUNITY PLANNING

The theme song of many of the 14 sections was the need for local community planning and action, with emphasis on the word "local." Therefore, the discussions and conclusions of this section are of unusual significance.

The following basic assumptions and recommendations were agreed to by the section participants:

BASIC ASSUMPTIONS

1. Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.
2. Health is a function of the community's total way of life, and planning for health should not be separated from planning for economic and social well-being.
3. The effective furtherance of health is dependent upon the interest, aggressive support, and participation of the entire community—professional and lay individuals and groups.
4. Citizens can act most effectively when there is proper machinery for planning and action at local and state levels. Local autonomy should be safeguarded. Special skills and interests should be fully utilized.
5. The development and maintenance of full-time official health units and essential health services are basic to community planning for health. The promotion of optimal health is equally a community responsibility.

RECOMMENDATIONS

1. Encouraging the formation of local and state health councils for coordination of efforts, the pattern to be developed in accordance with local needs—rural as well as urban.
2. Making health councils a part of social planning bodies. Such councils should be made up of all agencies and of individuals concerned with health. They should be truly representative of the entire community and should make full use of natural community leaders.
3. Coordination and cooperation of governmental and voluntary agencies at national, state,

and local levels, with open channels of communication.

4. Governmental and voluntary agencies should be requested to dramatize health needs to the nation, using all possible channels of information, and to locate and make available qualified persons to stimulate and advise local and state groups.

COSTS AND FINANCING

On the matter of increased costs and expenditures for health services, the section stated it "recognizes that the necessity for increased expenditures must be accompanied by recognition and acceptance of values to be attained by individuals and families through any increase in costs and it believes that state and community planning groups, councils, or committees, organized and financed on a permanent basis, is a useful if not an indispensable means of accomplishing such recognition and acceptance."

SECTION ON LOCAL PUBLIC HEALTH UNITS

Under the chairmanship of Dr. Haven Emerson, the Section on Local Public Health Units did a constructive job, using the following skeleton of basic policies and proposals suggested by him as the basis for its discussions:

1. Each state health department must declare and publish, and promote a plan for total coverage of its area with units of local health service for population groups of a size to permit economical and efficient technical public service.
2. Financial support, at least one-half on a local basis, will be needed.
3. A state-wide health council should be developed.
4. The present pattern of local public health service has proved reliable but the door should not be closed to services to cover new needs and to new discoveries.
5. It is essential to press upon the people an insatiable demand for better health—better a high goal not at once attainable than indifference or tolerance of mediocrity.
6. The health of the nation is based on the competent performance of established health functions at the local level of government where local initiative, responsibility, and resources are involved by the power of local public opinion. "Any other pattern will prove more costly, wasteful, unacceptable to the people served, and impersonal to the degree of ineffectiveness."

FULL-TIME UNITS ESSENTIAL

The section's resolutions committee developed the following which were accepted by the section:

1. Complete coverage of the nation with full-time local health units, capable of applying the science of preventive medicine directly to individuals and families, is fundamental to the effective functioning of all health programs, and the attainment of this goal should be given first consideration in any nationwide popularly desired and Federally assisted program for national health.
2. The attainment of complete coverage of the nation with full-time local health units is a joint responsibility of local, state, and Federal Governments, and it is recommended that every

effort be made to obtain adequate local, state, and Federal appropriations for the establishment, operation, and maintenance of full-time adequately staffed local health units throughout the nation.

3. This section endorses the present efforts of the State and Territorial Health Officers, the National Congress of Parents and Teachers, and many other national organizations in supporting legislation that is designed to achieve the objectives set forth in the foregoing recommendations.

SECTION ON PROFESSIONAL PERSONNEL

This section attracted considerable interest as it was concerned with a problem common to practically all of the sections, that of the acute shortage in professional, scientific, and technical personnel.

At the section's final session, Federal Security Administrator Ewing spoke, requesting consideration of some action to further postgraduate and retraining programs for personnel, especially physicians, and advocating the possibility of such steps as compulsory attendance at refresher courses or periodic examination for licensure. The section took no action after certain delegates had pointed out that many physicians now engage in postgraduate work and that efforts are being made constantly to meet additional demands for such training.

MORE PERSONNEL NEEDED

The following statements and suggestions were presented to the section by a sub-committee on medical personnel:

Attention should be devoted to increasing the output of physicians; medical educators should make careful surveys to determine how they may best increase the number of graduates without lower standards.

More Negro physicians should be trained; education of Negroes in general should be improved so there may be a larger supply qualified to enter medical schools. Efforts to increase supply must assure continuance of high standards. Periodic analyses of the demand for physicians should be developed.

NEED FOR FUNDS

Maintaining the present supply and quality of physicians is definitely a problem of financing.

There is evidence that contributions from private sources and state and local governments will not be sufficient to meet the financial needs of a sound and expanding program of medical education; some form of Federal support appears to be necessary.

SHOULD BAR FEDERAL CONTROL

Federal appropriations should entail no Federal control of the administration, curriculum and student admissions of medical schools; continuity of support should be assured; funds should be given in such a way as to increase rather than decrease the stimulus and responsibility for local support.

Support will be needed in three areas: (a)

For general operation, (b) for capital improvements, (c) for student support.

SHOULD ATTACH NO STRINGS

With respect to student support, funds should be provided so as to widen the opportunity for medical training of qualified individuals and Federal aid should carry no obligation to serve in any specified capacity after graduation.

DENTAL AND NURSING REPORTS

Recommendations that Federal aid be supplied to assist dental schools and dental students were presented by the sub-committee on dental education.

A sub-committee on nursing stated that the most immediate problems facing the nursing profession are the need for improvement of employment practices and the need for interpreting the increased demand for nursing services to the public.

It offered the following recommendations:

"Nursing education should be the responsibility of the institutions of higher learning whose primary function is education. Nursing education should be available to qualified applicants without discrimination as to race, color, or sex. Two years of general education beyond the high school level is recommended. The number of schools should be commensurate with social, economic, and educational planning (a smaller number of schools could produce the number of professional nurses needed more economically).

A sound system should be established for financing nursing education and nursing service. Financial aid for qualified schools should be secured from local, state, and Federal sources as well as from gifts and endowments. Scholarships for qualified students otherwise unable to finance their nursing education should be made available through the schools. Fellowships should be made available to encourage advanced training of teachers and research workers in nursing. Research funds should be secured to: improve the practice of nursing; investigate the use and need for professional nurses, practical nurses, and other auxiliary workers; study the role of the nurse in the health team.

There should be bi-annual re-registration and educational facilities here should be made available to nurses in other countries.

SECTION ON HOSPITAL FACILITIES

Role of the hospital in an expanded health program was given extensive consideration in the Section on Hospital Facilities. Final conclusions and recommendations of the section were as follows:

The program under the Hospital Survey and Construction Act should be continued and extended under a policy of flexibility permitting adaptation as may be required to meet changing needs. The present authorization of \$75,000,000 per year should be increased.

The program under the above act and the hospital program of the Veterans Administration should be closely integrated in the interest of good planning. Hospitals within service areas should be functionally or organically associated

with one another so that the patient may benefit from the resources of all.

The full cost of hospital services for patients for whom governmental agencies have assumed responsibilities should be paid from tax funds. This same principle should be observed by non-governmental agencies purchasing hospital care.

Hospitals and health departments and all other health agencies should seek every method for coordinating their efforts and integrating their functions in the interests of greater efficiency and service. Diagnostic clinics, out-patient services and home medical care, and allied programs should be developed more extensively in extending health services for all.

Hospitals should intensify and extend their basic activities in research and education. Preventive medical and dental service, and public health education should be carried out more widely as regular functions of the modern hospital. Insofar as possible, the general hospital should provide facilities for the care of all types of illness, with increased attention to the care of the patient with long-term illness.

The pressing need for additional facilities for the care of the mentally ill and chronic diseases in general hospitals makes it necessary that special emphasis be given to this problem in the original state hospital plans and any revision of these plans under Public Law 725. Careful study to develop recommended standards is needed in this area for the guidance of state agencies under this Act.

To develop and adequately meet good standards of patient care, it is recommended that all hospitals, nursing homes, and other facilities for the care of the sick should meet at least minimum standards through the mechanism of licensure.

The control of local facilities be by the people in that locality on a cooperative or a community basis where possible with an elected board of Directors, representative of lay and professional groups.

Lay and professional organizations and governmental agencies should join in conducting a health education program and in developing plans for adequate facilities and health services which will include well-coordinated and highly integrated networks, mobile units, clinics, community hospitals, regional hospitals, and great medical centers.

SECTION ON CHRONIC DISEASES

This section under the leadership of Dr. James R. Miller offered the following conclusions regarding care of the chronic disease patients and the aged.

Vigorous educational activities are needed to awaken the public, medical profession, and industry to the implications of the increasing prevalence of chronic disease and an aging population, and to the need for additional rehabilitation personnel and institutional facilities.

The chronically ill and aged should not be barred from useful work but schedules should be set up showing what types of work these persons can perform as a guide to employers.

Best approach to the problem of chronic disease is through education, linked with the periodic health examination and improved facilities and techniques.

There is great need for expanded and improved institutional facilities and this cannot be met

without additional financial assistance from local, state, and Federal governments.

Uniform and universal procedures for judging and licensing such institutions should be established.

A national commission on chronic diseases should be created to work with state and local organizations. Planning committees should be established in local communities and a single state agency given the responsibility for this work.

SECTION ON MATERNAL AND CHILD HEALTH

Following are some of the pertinent recommendations which came from this section:

A vigorous program of research in matters related to child life should be conducted and supported when necessary by increased Federal grants. A central clearing house on research problems and projects should be established. Federal grants should be increased and extended to provide training of professional personnel responsible for medical care and health supervision of mothers and children.

Appropriate Federal agencies and professional organizations should develop standards of care for maternal and child health. Hospital licensing systems should be recodified to assist in providing high standards of care.

A positive program of mental health should permeate all services for mothers and children. A vigorous program of education of parents in child rearing should be undertaken. Local communities should develop experimental projects designed to solve local problems. Accident prevention should be considered a major responsibility of state and local health departments.

Critical study should be made of laws and regulations which prevent children from securing available health services, with a view to removing such legal limitations.

The Federal Security Administrator should call a national conference on school health to be followed by similar conferences called by governors and local officials. Services for the rehabilitation of physically and mentally handicapped children should be expanded with increased Federal and state support and coordinated with programs of voluntary agencies.

Federal and state aid should provide for the extension and improvement of an integrated program of health instruction. An essential part of all health, education, and welfare programs for mothers and children is a comprehensive program of nutrition service and education.

SECTION ON RESEARCH

Headed by Dr. Andrew C. Ivy, this section stressed the acute need for more trained scientists in medical research and for additional funds with which to keep and secure more well-qualified men in this field. It was generally agreed that government would have to provide more financial aid for training research scientists and for establishing more research facilities. An over-all plan should be developed but tying money too specifically to projects should be avoided. A national educational campaign showing the values of medical research and pointing

out the dangers of the current anti-vivisection campaign should be initiated and vigorously supported.

SECTION ON REHABILITATION

Among the pertinent suggestions made by delegates to this section, headed by Dr. Henry H. Kessler, were the following:

More public education is needed. Closer co-ordination between all agencies should be developed and more schools for the vocationally handicapped should be opened. Federal support for teaching rehabilitation experts, for surveys on facilities and the number of handicapped, and for research in prosthesis seems to be necessary. Greater interest should be taken by the medical profession in physical medicine. There is an acute shortage of trained professional personnel in this field. Every hospital of 50 beds or more should have a department of physical medicine, with a teaching program. Many more physical and occupational therapists are needed. Rehabilitation centers should be established. Sound vocational guidance and counseling are essential. The program is gaining but is handicapped by shortages of men, money, and facilities.

SECTION ON ENVIRONMENTAL SANITATION

Final report of this section stressed the following:

Greater participation by citizens in environmental sanitation matters. Need for public education concerning the menace of water pollution, food air-borne infections, and other such hazards. Representation of public health agencies on water supply and conservation boards.

Joint campaigns by Federal, state, and local authorities to correct and abate surface water pollution and to develop and protect underground water resources.

Expansion of the pasteurization of milk; compulsory refrigeration of foods capable of carrying toxin-producing bacteria; education of food handlers; dissemination to consumers of information on the protection of perishable foods; development of sanitary codes by food industries.

More laboratory facilities for food testing. More effective food and drug regulations. Better housing conditions. Development of sanitary standards for community planning.

Need for more industrial hygiene personnel and extended research in new industrial health hazards. More effective insect and rodent control; continued work in control of malaria and Rocky Mountain spotted fever. Need for more research personnel and more effective coordination of research activities; expansion of research into new fields.

More effective utilization of personnel and enlargement of health agency facilities to service existing programs; better coordination of Federal, state, and local activities.

SECTION ON NUTRITION

Dr. Frank G. Boudreau was chairman of the Section on Nutrition which listed the following recommendations based on the section discussions:

There shall be created a national nutrition council and state-wide nutrition committees or councils should be established.

A cooperative nutrition education program should be developed and promoted on the national, state, and local levels. Public opinion should be aroused to the importance of nutrition education as a part of a health education program.

Food production programs should be based upon dietary needs in terms of an expanding population, giving due consideration to the agricultural problems involved. Recognition should be given to the relationship between the living natural resources of our country—forests, water sources, animal life, and productive soils—and the health of our people. Increased attention should be given to the improvement of the nutritional quality of food as produced and to the conservation of its nutrients from the farm to the consumer's table.

Recognizing that malnutrition exists among many individuals and groups despite a plentiful average per-capita nutrient supply, special consideration should be given to production and distribution measures which will make an adequate and acceptable diet more readily available to these groups.

Research on the nutritive value of foods and their combinations, as they occur commonly in diets, should be encouraged to keep pace with advances in research on the physiological aspects of nutrition.

A planned program of instruction in nutrition should be included in the training of physicians, health officers, dentists, nurses, health educators, social workers, and teachers. Personnel with specialized training in nutrition must be increased in number. To accomplish this an increase of available funds is needed to provide for research, for scholarships, and to subsidize special projects for demonstration and field training in community and public health.

SECTION ON MENTAL HEALTH

Discussions in this section, of which Dr. William C. Menninger was chairman, centered on the following:

Psychiatric personnel and facilities, non-psychiatric aspects of mental health; and public education in relation to mental health.

A sub-committee gave a detailed account of the types of institutions which required psychiatric personnel in order to deal with the problems of mental illness that come within their jurisdiction.

The committee also stressed the importance of providing psychiatric orientation to those community organizations or institutions which in their dealings with normal individuals could play an important part in early diagnosis of mental illness. Such early diagnosis is of utmost importance. The agencies believed to be important in the finding of the early case most suitable for therapy are public health departments, nursery schools, public schools including kindergarten, higher educational agencies including vocational and other counselings, medicine in industry, general hospital and out-patient clinics, social service agencies, ministerial counseling, and the courts.

A second sub-committee emphasized the fol-

lowing: Chief responsibility for the prevention of mental ill health does not lie primarily with the psychiatrist but with the public at large, because people such as clergy, teachers, lawyers, social workers, nurses, recreation and group workers, law enforcement officers, public health personnel, representatives of management and labor, and many others, by the very nature of their work, are constantly presented with opportunities for recognizing and helping to some extent people with emotional problems. They can learn how to be of help by learning the principles of mental health while on the job and in the actual technical training for their specific fields, as well as by consultations with organized psychiatric groups.

The social, economic, and political problems of our society have a direct bearing on the mental health of citizens. No housing, continued inflation, racial and religious prejudice and discrimination are but a few of the major social ills which undermine the personality defenses and destroy mental health. Governmental and private agencies as well as all private citizens have a direct responsibility in seeing that something is done about these social problems.

A major campaign of public education must be undertaken to remove the misconceptions about mental ill health; to develop a sound public understanding of the nature, treatment, and prevention of psychiatric disorders and to stimulate active public support for, and use of, sound mental health programs. This is a responsibility which can be carried out by governmental, private, and commercial agencies at the national, state, and local levels.

SECTION ON DENTAL HEALTH

Following are some of the observations and recommendations made by the Section on Dental Health:

Dental diseases afflict more than 90 per cent of the people. The most logical and effective means of ultimately bringing better dental health to the American people is adequate dental service for children.

The following principles for a 10-year program to achieve dental health goals were enumerated:

Adequate provisions should be made for research which may lead to the prevention or control of dental diseases.

Dental health education should be included in all basic educational and treatment programs for children and adults.

Dental care should be available to all regardless of income or geographic location. Programs developed for dental care should be based on the prevention and control of dental diseases. Dental health is the responsibility of the individual, the family and the community, in that order. When this responsibility, however, is not assumed by the community, it should be assumed by the state and then by the Federal government. The community in all cases shall determine its methods for providing service.

General recommendations for Federal financial assistance for dental education and dental research were adopted as well as recommendations for the training of more dentists and auxiliary dental personnel, for more facilities, and for better distribution of dentists between urban and rural communities.

Fort Steuben Academy To Hold Assembly on June 10

The First Annual Post-Graduate Assembly of the Fort Steuben Academy of Medicine will be held in the Masonic Temple, Steubenville, on June 10. The affair will bring to a close the Academy's series of monthly programs for the season which began in October.

The Assembly will be an afternoon and evening affair, beginning at 1:30 p. m., daylight saving time. Dinner will be served at 6:30 p. m.

The program includes the following:

Dr. Max Minor Peet, Ann Arbor, Mich., "Hypertension";

Dr. Bela Schick, New York City, "Modern Infant Immunization";

Dr. S. O. Freedlander, Cleveland, "Medical and Surgical Approach of Pulmonary Tuberculosis"; and

Dr. Ross Golden, New York City, "Intestinal Obstruction."

During the year the Academy held a series of outstanding meetings and scientific sections featuring such guest speakers as the following:

Dr. Francis C. Grant, head of the department of neurosurgery, University of Pennsylvania; Dr. Gordon McNeer, associate attending surgeon, gastric and tumor service, Memorial Hospital for Cancer and Allied Diseases and consultant surgeon, gastric service, Roosevelt Hospital, New York City.

Dr. W. W. G. MacLachlan, University of Pittsburgh and chief of internal medicine, Mercy Hospital, Pittsburgh; Dr. Earl W. Netherton, chief of the department of dermatology, Cleveland Clinic; Dr. Benjamin S. Kline, chief of laboratory service, Mt. Sinai Hospital and associate professor of pathology, Western Reserve University, Cleveland.

Dr. Thaddeus L. Montgomery, head of department of obstetrics, The Jefferson Medical College, Philadelphia; Dr. I. S. Ravdin, professor of surgery, University of Pennsylvania; Dr. Edward Tuohy, head of department of anesthesia, Mayo Clinic; and Dr. Frank H. Lahey, director of Lahey Clinic and surgeon in the New England Deaconess and New England Baptist Hospital, Boston.

Pennsylvania Alumni

University of Pennsylvania Medical Alumni will hold a dinner at the Convention of the American Medical Association in Chicago, Wednesday, June 23, 1948, at the Lake Shore Club, 850 Lake Shore Drive. On arrival in Chicago, alumni are invited to contact Miss Frances R. Houston, executive secretary of the Medical Alumni Society, at the University of Pennsylvania registration booth.

Child Hygiene Division of Ohio Department of Health Is Carrying On Extensive Program in State

THOUGH the scope of the Division of Child Hygiene is as broad as the State's child population, services primarily are directed to maternal and child care in rural areas and areas of economic need. In its broader application of services, the Division attempts to carry on a state-wide educational program on health for maternal patients and for mothers. Two of the newest projects promoted by the Division are the program of child health conferences and the conservation of hearing program.

BUDGET

Like that of all public agencies, the program of the Division is limited to the extent of its budget. The small appropriation from the State has been re-enforced through substantial grants-in-aid from the U. S. Children's Bureau. More than 96 per cent of the Division's funds for the coming year are provided by the Federal Government. The Federal appropriation to Ohio for the coming fiscal year is \$325,929, in contrast to somewhat less than \$10,000 provided through the State budget. Funds for maternal and child health services are provided through Title V of the Social Security Act, while funds for other types of services through the U. S. Public Health Service are provided under Title VI.

AID TO LOCAL DISTRICTS

A large portion of the budget goes toward aiding local health units. Salaries are paid out of the Division's budget for 37 public health nurses who devote a considerable portion of their time to maternal and child health work in rural communities. These nurses are assigned to organized local health units. Nurses employed through maternal and child health funds are located in the following counties or communities: Adams-Brown (two), Ashland, Athens, Clermont, Clinton, Crawford, Cuyahoga (two), Darke, Defiance, Erie, Franklin (vacant at present), Greene (three), Hancock, Hocking-Vinton, Logan, Lorain, Lucas, Madison, Marion, Meigs (two), Miami, Muskingum, Portage, Sandusky (vacant at present), Seneca, Summit, Wayne, Wood, and Wyandot. Two additional nurses are working in Columbus and one in Martins Ferry on special projects.

Funds also are provided to pay salaries of several clerks in local health unit offices.

MATERNAL HEALTH

The Division provides supervisory and consultation services to 176 maternity hospitals in the State. Activities in this field include general supervision of maternity hospitals in connection with licensing of such institutions, conferences with hospital administrators and health commis-

This is one in a series of articles on the organization, functions, and programs of the Ohio Department of Health and its subdivisions, under Dr. John D. Porterfield, director. Articles on the recent reorganization of the Department, on the Hospital Facilities Office, and on the newly created Cancer Division, appeared in preceding issues of *The Journal*.

sioners regarding the improvement of facilities, review of plans for new maternity hospitals or remodeling of existing institutions, and consultation with local health authorities regarding maternal health problems and programs.

This service includes surveys and studies of existing facilities and need of additional maternity hospital services. The urgent need of more maternity units is emphasized by the report that in Ohio during 1939 only 46 per cent of births occurred in hospitals while in 1947 the proportion had increased to 90 per cent. During 1947, blueprints for 25 maternity units were reviewed by the Division.

Services include distribution of educational literature on infant and maternal care to patients. Scientific literature on maternal and child care is distributed for the benefit of hospital personnel.

CHILD HYGIENE

A program of child health conferences is being emphasized by the Division in cooperation with the Ohio State Medical Association and local medical societies. This program is gradually expanding. At the present time, the Division is remunerating physicians for conducting conferences in 61 centers. In 1947 a total of 1,608 infants and 2,016 children, one to six years old, attended 533 conference sessions in 31 centers. Visits averaged 3.4 per infant and 2.7 per child over one year, making a total of 5,489 infant visits and 5,409 children visits. Since the number of conference centers has approximately doubled since last year, health officials predict a proportionate increase in the number of children who will be examined this year.

Purpose of the conferences is to teach parents the value of providing continuous health supervision for their children and of securing prompt medical care after defects have been discovered. Physicians are appointed by the local health commissioner upon recommendation of the county medical society. Remuneration is \$5.00 per hour with a maximum of \$15.00 per conference.

Treatments are not given at the conferences, however, immunizations are administered to those

eligible. Parents are advised as to dietary needs of children. Children found in need of treatments are referred to family physicians. Children of parents who cannot afford the services of a private physician are referred to the proper welfare agency.

Child health work continues to be largely educational due to limited personnel in the Division. Bulletins on infant and child care are widely distributed to parents, physicians, and maternity hospitals.

NUTRITION SERVICES

The Division employs a chief nutritionist and six district nutritionists. Each district comprises approximately eight to ten counties. Nutritionists assist in school lunchroom projects and school health education programs. They were especially active last season in helping with canning projects to provide food for school lunchrooms. They make supervisory visits to county homes and other types of public institutions. In cooperation with the Tuberculosis Division they also are visiting tuberculosis sanatoriums where they make surveys and consult with local personnel in regard to nutrition problems. They also do in-service training in the field of nutrition with public health nurses.

CONSERVATION OF HEARING PROGRAM

Senate Bill 188, which became effective January 1, 1948, requires that vision and hearing tests be given all children receiving a physical examination or inspection in schools. The law further specifies that the Director of Health shall approve testing devices and methods of testing and make available suitable school record forms for recording tests and follow-up treatment of defects.

For some time before enactment of the law, the Division, in cooperation with the Department of Education, was in process of developing a conservation of hearing program.

The Division has available the necessary forms for carrying out the tests and has a list of equipment approved by the Director of Health. Also the Director of Health has met with a committee of consultants to work out methods of testing.

The Division has on its staff two hearing consultants who are available upon request to assist local health departments in setting up conservation of hearing programs. They train personnel and assist the local health authorities in conducting diagnostic clinics. Children found with hearing defects are referred to these clinics for examination by qualified otologists. Nurses use a follow-up system through which families of those children found with defects are urged to have children consult the family physician or an otologist.

DENTAL SERVICES

From 45 to 50 per cent of the budget of the Division of Dental Hygiene comes from Federal

funds through the Division of Child Hygiene. The Division of Dental Hygiene operates two large trailers which are used to carry out a prophylactic and corrective dental program in rural schools. Costs of trailers and salaries of dentists in charge are paid from maternal and child hygiene funds. The Division of Dental Hygiene has worked out with the Ohio State Dental Association a corrective dental care program.

Biologics for the protection of children against smallpox, diphtheria, whooping cough, and tetanus are purchased by the Division for distribution to local health departments and practicing physicians. The Division also supplies silver nitrate for use in newborn infants' eyes.

More than 400,000 pieces of literature, either published or purchased by the Division, were distributed last year.

EDUCATION PROGRAM

The Division again will provide funds from the U. S. Children's Bureau as a grant to Children's Hospital, Cincinnati, to assist it to carry on its advanced pediatrics nursing course. The grant this year will be \$8,200.

A grant this year of \$6,500, again, will go to Western Reserve University to help in the field training program in public health nutrition education.

The Children's Hospital, Columbus, will receive this year a grant of \$8,000 to assist in an educational program for nurses in the care of premature infants. Nurses from maternity services in small rural hospitals are sent to this hospital for periods of two months' intensive training in the care of premature infants.

An additional amount of approximately \$11,000 has been provided in the budget for postgraduate training for hospital nurses in the field of pediatrics.

OTHER SERVICES

The Division cooperates with the Ohio Department of Public Welfare in many matters pertaining to maternal and child welfare. It also works closely with the State Department of Education. Through a cooperation program, it also works with the Division of Vital Statistics relative to birth registration.

ADMINISTRATION

Chief of the Division of Child Hygiene is Dr. Susan P. Souther, a graduate of Johns Hopkins University School of Medicine, who came to the Ohio Department of Health in 1941. She received a Master's Degree in Public Health from the Harvard School of Public Health, and is certified by the American Board of Pediatrics. The Medical Advisory Board of the Division meets two or more times a year to review the work of the Division and to act in an advisory capacity on policy.

Induction of Physicians in Certain Categories Provided In Both Senate and House Draft Proposals; Measures Analyzed; Action of O. S. M. A. Committee

AS this issue of *The Journal* went to press, both houses of the Congress were attempting to adjust their differences on proposals to reactivate the Selective Service System—a question of vital importance to the medical profession.

The final form of the legislation, assuming that some law will be enacted, cannot be predicted at this time. However, each bill includes a provision which would require the special registration of physicians up to 45 years of age and authorize special calls for physicians regardless of the regular induction procedures for other classes of registrants.

PROVISIONS OF SENATE BILL

Senate Bill 2655 carries the following provisions:

"Sec. 4(c) (1). Notwithstanding any other provision of this Act, the President is authorized; pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical and dental professions and allied specialist categories who have not attained the age of forty-five at the time of such call in such classifications as he shall determine. Persons in medical and dental categories shall be inducted in accordance with the following priorities:

"First. Participants in the Army specialized training program or similar programs conducted by the Navy and persons who were deferred from training and service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and who have had no active service as commissioned officers exclusive of time spent as intern.

"Second. Those who did not have active service during World War II.

"Third. Those who served the least numbers of full months during World War II.

"Persons called hereunder shall be liable for induction into the armed forces for training and service for twenty-four consecutive months, in accordance with such procedures as the President shall prescribe.

"(2) No doctor of medicine or dental surgery who, on the effective date of this Act, was established in his profession in the community in which he resides shall be called for induction under the provisions of this subsection, and no such doctor of medicine or dental surgery who is a member of a reserve component of the armed forces shall hereafter be ordered to active duty for more than one month in any calendar year (except for purposes of training), if the local board within the jurisdiction of which he resides has determined that the health of the community in which he resides will be unduly jeopardized as a result of his induction or service on active duty. The foregoing provisions of this paragraph shall not apply to any doctor of medi-

cine or dental surgery who participated in the Army specialized training program or any similar program conducted by the Navy, or who was deferred from service in the armed forces during World War II for the purpose of pursuing his medical or dental education, if he has not served on active duty as a commissioned officer for a period of more than ninety days exclusive of training duty or internship."

In a special statement which accompanied Senate Bill 2655, the Senate Committee on Armed Services emphasized the importance of the provisions which would permit local draft boards to exercise discretion in drafting physicians in order to see that local communities are not stripped of medical personnel.

The House version of the proposed Selective Service legislation differs somewhat from that of the Senate.

PROVISIONS OF HOUSE BILL

H. R. 6401 contains the following provision, which apparently attempts to protect the civilian population by limiting the number of medical officers per 1,000 men in the services:

"Sec. 4(c) (1). Notwithstanding any other provision of this Act, except sections 20(b) and 23, the President is authorized, pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical, dental, osteopathic, veterinary, pharmacy, and optometric professions, who have not yet reached the age of forty-five at the time of such call, in such professional categories as he shall determine, and persons called hereunder shall be liable for induction for not to exceed twenty-four months of service in the armed forces: **Provided**, that during the life of this Act there shall be, in the Army, including the Air Force, and in the Navy, including the Marine Corps, a ratio to total active strength of not to exceed five doctors of medicine and two dentists per one thousand men, one osteopath per five thousand men, one veterinarian per two thousand men, and one pharmacist and one optometrist per three thousand men.

"(2) In inducting persons pursuant to paragraph (1) of this subsection, the President shall induct, in the following order of priority:

"First. Those who participated as medical or dental students in the Army specialized training program or similar programs administered by the Navy, and persons who were deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and have had no active duty as commissioned officers.

"Second. Those who participated in the Army specialized training program or similar programs administered by the Navy and who have served on active duty as commissioned officers for less than twenty-four months (exclusive of time spent as intern).

"Third. Those who are less than thirty-five

years of age and have had less than ninety days' prior active honorable military or naval duty.

"Fourth. Those who are over thirty-five years of age and have had less than ninety days' prior active honorable military or naval duty.

"Fifth. Those whose total active honorable military or naval duty is less than twenty-four months.

"Sixth. Others as prescribed by the President."

ACTION OF O.S.M.A. COMMITTEE

The Committee on National Emergency Medical Service of the Ohio State Medical Association for the past month and a half has been continuously in touch with the Council on National Emergency Medical Service of the A.M.A., and with Ohio members of the Congress on the question of the proposed Selective Service legislation.

On April 12 the State Association's committee advised Ohio's members of the Congress that there were serious objections to the induction of physicians as a special class. Similar objections were made by the A.M.A.

At a meeting in Columbus on April 18, the State Association's committee reaffirmed this action, and adopted the following statement, copies of which were sent to Ohio members of the Congress:

RECOMMENDATIONS MADE

"1. The committee urges immediate establishment of a civilian medical board as a functioning agency of the National Security Resources Board.

"2. If a Selective Service program is established and if it includes a provision for the drafting of physicians, a priority system should be set up for the selection of physicians. The following priorities are suggested:

"(a) Physicians who have received their medical education at expense of Federal Government and have not had active military duty as a medical officer.

"(b) Physicians who have received their medical education at the expense of the Federal Government and have had less than 24 months of active military service as a medical officer.

"(c) Physicians under 45 years of age who have had no active military duty as a medical officer.

"3. In time of a national emergency adequate provision must be made for protection of civilian population through maintenance of adequate effective medical personnel for its care and this must be considered prior to calling up physicians for the armed services."

The committee also adopted the following resolution:

"That the A.M.A. Council on National Emergency Medical Service do everything possible to bring about the uniformity of procedure between the armed services and Selective Service in event a Selective Service program is established on matters of physical qualifications, physical examinations, paper work, etc., in order to eliminate confusion such as occurred during World War II and

to reduce paper work and unnecessary effort on the part of medical examiners, etc."

BILLS ESTABLISH PRIORITIES

Apparently the Armed Services Committees of both the Senate and House feel that physicians must be called up as a special group in order to provide the services with an adequate number of medical officers. However, it is of interest to note that both proposals establish a priority system for induction of physicians, similar to the recommendations offered by the Committee on Emergency Medical Service of the Ohio State Medical Association.

Moreover, in the statement which accompanied the Senate measure, the Senate Armed Services Committee called attention to the importance of a Medical Advisory Board within the National Security Resources Board to assist in allocating medical personnel between the armed forces and the civilian population—a point emphasized in the statement adopted by the committee of the Ohio State Medical Association.

WORKING ON DISASTER PLAN

The State Association's committee also is working on details with respect to establishing adequate machinery for handling medical services in an over-all Ohio Disaster Program which would be placed in operation in event of war. Conferences have been held with Governor Herbert. A sub-committee of the main committee is working on this matter in order that recommendations can be submitted to the Governor at the appropriate time.

A. M. A. Board Chairman Named to Council of World Medical Assn.

Dr. Elmer L. Henderson, Louisville, Ky., chairman of the Board of Trustees of the American Medical Association, has been elected a member of the Council of the World Medical Association. He fills the vacancy created by the appointment of Dr. Louis H. Bauer, Hempstead, N.Y., a member of the Council, to the office of secretary-general of the Association. Dr. Bauer also is a member of the Board of Trustees of the A.M.A.

The Council, consisting of 14 members representing 12 different countries, held a four-day meeting in New York, April 26-29. The Council is the governing body of the World Medical Association, which was organized in Paris on September 18, 1947, for the purpose of promoting closer ties among national medical organizations throughout the world. The Council's New York Session was the first since the association's organization meeting in Paris.

Several A.M.A. officials, in addition to Drs. Bauer and Henderson, were present at the meeting.

President of Ohio Medical Indemnity Urges Physicians To Cooperate Fully So That Organization Can Fulfill Its Obligations to the Public and the Profession

FOLLOWING is the complete text of a communication, dated May 4, 1948, addressed to the officers, delegates, and members of the Ohio State Medical Association by L. Howard Schriver, M.D., Cincinnati, president of Ohio Medical Indemnity, Inc., and former president of the Ohio State Medical Association which founded and is actively sponsoring Ohio Medical Indemnity, the "Doctors' Plan."

The communication speaks for itself and *The Journal* recommends to each member that he read it carefully, weighing studiously the comments made by Dr. Schriver, who has taken a leading active part in the formation and administration of Ohio Medical Indemnity:

* * * *

TEXT OF LETTER

TO: The Officers, Delegates, and Members of the Ohio State Medical Association.

On behalf of the Officers, Directors, and Personnel of Ohio Medical Indemnity, Inc., I wish to express sincere appreciation for the passage of a resolution by the House of Delegates at the Annual Meeting in Cincinnati, denoting confidence in and appreciation of the conduct and growth of Ohio Medical Indemnity, Inc.

Although Ohio Medical has grown very satisfactorily in the past two years, we realize there is yet much to be done. The present subscriber enrollment is 345,000. Our goal in Ohio must be 2,000,000 or more.

Financially Ohio Medical is sound and every precaution has been and will be taken to safeguard its financial structure. As Ohio Medical grows it will be possible to expand coverage to subscribers and liberalize the indemnities paid. We realize that in many services the profession has underwritten the services rendered. The contract has been liberalized in 1947 and we are hopeful of greater progress in this respect as our finances permit. We asked the cooperation of the profession in this.

DANGEROUS PRACTICE

There has come to our attention instances of what seemed to be overcharges for services rendered subscribers. These have not been numerous. However, as President of Ohio Medical Indemnity, I would not fulfill my obligation to the profession of Ohio if I did not call attention to the danger of such practice.

The purposes of Ohio Medical Indemnity, Inc., are practically two in number:

First: To function as the instrumentality through which the middle and low income groups of people in Ohio can procure good medical attention.

Second: By satisfactorily performing the above to insure the unregimented freedom of the medical profession.

Personally, I believe that with cooperation and patience on the part of the profession, both of these functions will be satisfactorily fulfilled. However, without the cooperation of the profession, Ohio Medical Indemnity can never succeed. If it fails there can be no doubt that the profession will definitely be regimented.

FORCE FOR GOOD OR BAD

I know of no more potent force that can contribute to the failure of Ohio Medical Indemnity,

Inc., than the charging of fees for service in addition to the schedule of indemnities, where not thoroughly warranted by the economic status of the patient. On the other hand, I know of no greater force for the creation of healthy public relations and confidence of the public in the profession, than abstinence from such practices. When a member of the profession charges unwarranted additional fees, he does the entire profession a disservice.

We, of Ohio Medical Indemnity, realize fully that certain items in the schedule of indemnities are inadequate. We pledge that we will make every effort to increase these as soon as we can. Ohio Medical Indemnity at present is making a thorough investigation with the hope that in the not too distant future it will be in a position to expand its indemnity coverage to hospitalized medical illnesses and other procedures not covered at this time.

To the Blue Cross Plans, I wish to express sincere appreciation for their splendid assistance and cooperation which has in great measure made possible the success of Ohio Medical Indemnity.

The Board of Directors, Executive Committee, and Mr. Charles Nelson, the Executive Secretary of Ohio State Medical Association, have diligently and earnestly served your Ohio Medical Indemnity without compensation. The Executive Vice-President, Mr. Charles Coghlan, has done splendid work. I take this opportunity, as a member of the Ohio State Medical Association and as president of Ohio Medical Indemnity, Inc., to express my sincere thanks and appreciation to each of them.

L. Howard Schriver, M.D.,
President,
Ohio Medical Indemnity, Inc.

Conference of County Officers

The Third National Conference of County Medical Society Officers will be held from 10 a. m. to 4 p. m. on June 20 at the Palmer House, Chicago.

The purpose of the conference is "to develop a working partnership between the American Medical Association and every physician." All county medical society officers are invited to attend. Chairman of the organization is Dr. A. M. Mitchell who may be addressed in care of the A.M.A. Ohio chairman is Dr. George H. Woodhouse, Pleasant Hill.

Up-To-Date Review of V.A. Out-Patient Program Procedures; Suggestions for Physicians Treating Eligible Veterans

FOR the benefit of physicians who are co-operating with the Veterans Administration in out-patient examination and treatment of eligible veterans, the following suggestions have been made by Dr. States D. McCoy, Chief Out-Patient Division, Medical Service, of the Columbus Branch Office of the Veterans Administration.

The review, covering certain phases of the V.A. "home-town" medical program for Ohio veterans with service-connected disabilities, points out some of the difficulties encountered in administration of the program and offers recommendations as to the manner in which these difficulties can be alleviated.

1. Since January 1, 1948, it has been impossible to authorize out-patient treatment or private hospitalization for male veterans whose disabilities have not been actually rated as service-connected by the Adjudication Division of the V.A.

In other words the granting of "prima facie" service-connection is no longer possible, no matter how obvious it may appear to the examining physician that the condition for which treatment is requested was incurred in or was aggravated by service in the armed forces, until actual rating board action has been taken.

2. All letters of authorization have a definite limitation date. This is recorded in the lower right-hand block of V.A. Form 10-2568 under the caption "Period Covered by the Authorization." There must be a request for renewal if it is necessary that treatment be continued.

3. When a veteran has been hospitalized in a private hospital for treatment of an emergent condition which is service-connected, authorization for such hospitalization and treatment must be secured from the nearest V.A. office within 72 hours from the time of such hospital admittance.

If the V.A. is not notified within the three-day period it will be impossible to reimburse either the hospital or doctor for services rendered for the first 72 hours even though the veteran is perfectly eligible for such treatment had proper notification been given the V.A.

Very frequently the first three days of hospitalization involve the most expensive treatment, such as operations and so forth, and it is extremely unfortunate if that service cannot be paid for, merely due to the fact that proper notification was not furnished the V.A., thus depriving the doctor, hospital, and veteran of benefits to which they are entitled.

4. Exactly the same situation exists when the

V.A. is not notified by a physician within 15 days of the time emergency treatment was instituted in home or office for a veteran's service-connected disabilities. Such treatment cannot be paid for by the V.A. after the 15-day period has passed and again the veteran is deprived of treatment to which he would be entitled by law and the doctor is deprived of reimbursement for services rendered, merely because the 15-day time limit has elapsed and for no other reason.

5. If a participating physician receives authority to treat a veteran, payment for the services rendered is not automatic. The physician must submit a bill and also a report as to what services were furnished. If no billing is received within 30 days after the expiration date of the authority, it will be assumed that the service was not performed and the authority will be cancelled automatically.

6. A scientific medical diagnosis is necessary on a request for out-patient treatment because such treatment can only be rendered for the condition which is service-connected. A symptomatic diagnosis such as headache, abdominal pain, cough, pain in the chest, backache, is of no value inasmuch as service-connection cannot be established for symptoms only.

In such cases the doctor will receive a note from the V.A. stating that out-patient treatment cannot be approved inasmuch as the veteran cannot claim service-connection for the condition for which treatment is requested. If, instead of these symptomatic diagnoses, treatment had been requested for peptic ulcer, asthmatic bronchitis, residuals of skull fracture, etc., the V.A. could at once determine whether or not the veteran's condition is considered service-connected.

Reports of treatment on V.A. Form 10-2690a are frequently too brief and too routine. It is necessary that the V.A. have knowledge of the type of treatment the doctor is furnishing and a general description of the disability which will justify the need for further treatment.

If the authorization calls for an examination (and the V.A. frequently authorizes an examination on the first contact rather than a treatment) a detailed report must be submitted in order that a determination may be made to the veteran's eligibility for treatment.

7. When a veteran requires emergency hospitalization in a V.A. hospital and the community in which he resides does not have a V.A. office, it is requested that the doctor treating such a veteran make a collect telephone call to the nearest V.A. hospital and explain the situation

to the Chief, Admission Service, Registrar, or Officer of the Day, whereupon immediate authorization can be obtained for hospitalization, and if necessary, transportation authorized. It is much more expeditious to follow this procedure rather than to call a distant V. A. office or regional office.

8. When a fee-basis physician is treating a veteran at the expense of the V.A. and medication is indicated, these veterans should be sent to an authorized V.A. participating pharmacy for filling of prescriptions and should not be asked to pay for such medication out of their own pockets. If the veteran does pay for his own medication it is extremely difficult and usually impossible to reimburse him for these expenses. Furthermore, unless the case is an emergency, prescriptions for medication should be sent to the pharmacy in the nearest V.A. regional office. Such prescriptions should state that the physician is authorized to treat this veteran at the expense of the V.A. These prescriptions will be promptly filled by the regional office pharmacist and mailed to the veteran.

9. Pharmacies suffer a financial loss when physicians certify on prescriptions that they have authority to treat a veteran when they actually do not have authority. Any physician who knowingly writes a prescription and certifies in the legend that he has authority when he does not have authority is violating a Federal statute.

10. In the case of female veterans, private hospitalization in a civilian hospital can be authorized for any emergency condition whether service-connected or not when a V. A. hospital is not feasibly available. This is the only case in which private hospitalization can be authorized for a non-service-connected disability with the exception of those veterans who are enrolled in Rehabilitation and Education Training under Public Law 16. These veterans are entitled to any treatment which would prevent interruption of training. These veterans are also entitled to private hospitalization at the expense of the V.A. when an emergency exists and a V.A. hospital is not feasibly available.

11. Authorization for out-patient treatment can only be granted by medical officers of the V.A. and cannot be granted by any contact representative or member of a service organization. Such contact representatives or service organizations can be utilized for purposes of notification of private hospitalization, especially at periods of time when V.A. offices are not available. However, in such cases it should be stressed to such service organizations to notify the nearest V.A. office as soon as possible. If such notification is not received by the V.A. from such service organizations it would be necessary to state that

the V.A. was not notified of the treatment rendered.

12. It should be emphasized again that veterans on an out-patient basis are entitled to treatment for their service-connected disabilities only, and not for an acute illness which may develop subsequent to military service.

New Income Tax Regulations Will Lower Assessments

The Revenue Act of 1948, enacted April 2, over presidential veto will, "generally speaking," result in a tax reduction for physicians of 30 per cent or more, according to S. F. Noggle, Chief of Income Tax for the 11th Ohio Internal Revenue District. This reduction is largely the result of three changes in the law:

1. The amount allowable as a personal exemption was raised from \$500 to \$600. The credit for each dependent was likewise increased to \$600.

2. The same tentative normal and surtax rates as used in 1946 and 1947 were retained, but the 5 per cent reduction was eliminated and greater credit on the total tentative tax liability allowed on the following scale:

A. If total tentative tax liability is not over \$400, reduction is 17 per cent of the total.

B. Over \$400 but not over \$100,000, \$68 plus 12 per cent of excess over \$400.

C. Over \$100,000, \$12,020 plus 9.75 per cent of excess over \$100,000.

3. Husbands and wives will be permitted to file a joint return and to divide the combined taxable income by two. The tax will be computed on one segment of the divided income and multiplied by two. This enables the family to compute its tax in a lower bracket.

Other features of the act include the raising of the allowable standard deduction to 10 per cent of the adjusted gross income up to \$10,000. Under the old law the ceiling was 10 per cent of \$5,000.

Individuals 65 years of age or over will receive an additional credit of \$600 over their personal exemption. If the spouse has attained that age, an additional \$600 credit is also in order. A credit of \$600 is also for a blind individual and/or the spouse.

Those paying taxes on a quarterly installment basis may file an amended declaration by June 15, Mr. Noggle said. The blanks for this purpose will be mailed with the June 15 statements and the amount paid in June should be on the basis of the amended estimate. Withholding statements of those receiving salaries or wages were adjusted to correspond with the new law on May 1. Excess amounts paid in the previous four months will be refunded according to the tax return filed for 1948 early next year.

Ohio State Medical Golfers' Association Plans Tournament at Granville, July 19

FINAL arrangements have been completed to hold the 1948 O.S.M.G.A. Annual Tournament on the beautiful course of the Granville Inn in the hills of Licking County, on Monday, July 19, Mr. R. W. Elwell, Toledo, secretary, announced. In a recent survey of members of the Association, preference for this location was high on the list, running even with Columbus. As it was impossible to secure accommodations at any of the Columbus golf clubs, the committee decided on Granville.

SEPARATE MEETINGS PLANNED

The officers of the Association met during the O.S.M.A. Meeting in Cincinnati in April and agreed that the O.S.M.G.A. had come of age and could now stand on its own feet. Since the State Association meetings are to be held early in the Spring, it was necessary to set the golf tournament at a later date. The friendship and good fellowship that has always attended our annual golf parties are worthy of fostering and continuing. Participants are invited to bring their ideas as well as best golf to this year's event.

ALL DOCTORS INVITED

Very fine accommodations will be afforded golfers this year. Luncheon will be served at noon and a banquet in the evening (Granville Inn is known for good food). For those doctors who wish to play some warm-up golf on Sunday, the course will be available. The committee has reserved all rooms at the Inn for Sunday night. However, this is a small number and requests will be honored as they are received by the secretary. The Worden Hotel in Newark, seven miles from Granville, will be able to accommodate some of our members who plan to arrive

on Sunday. Columbus is about 35 miles from Granville and some may wish to stay there.

INVITATIONS FOR NEXT YEAR

Because the O.S.M.G.A. will hold tournaments later in the year, it will be possible for the membership to select a location and date for the following year. It is suggested that those

A. M. A. Golf Tournament

The American Medical Golfing Association will hold its 32nd Tournament on Monday, June 21, in Chicago in connection with the Annual Session of the American Medical Association. Olympia Fields has been reserved for the medical golfers' tournament. Dinner will be held in Olympia Fields C. C. Clubhouse, after which prizes will be awarded.

interested in having the tournament in a particular locality next year present an invitation at the meeting giving particulars.

STIMULANTS NOT AVAILABLE

Those who have never visited in Granville are assured that the surrounding country, the golf course, and the appointments of the Inn will be most pleasing. Those who like their liquid refreshments should take their own as none is served at the Granville Inn. However, an ample supply of fizz water will be available.

DEADLINE FOR RESERVATIONS

It is necessary in planning this kind of meeting for the committee to know the actual number of those who will attend. Those planning to attend are requested to fill in the Reservation Blank and mail to the secretary.

RESERVATION BLANK for 1948 Annual Meeting

OHIO STATE MEDICAL GOLFERS' ASSOCIATION

To the Secretary:

I am going to attend the Golf Tournament on July 19 at Granville, Ohio. I have enclosed a check to cover green fees, luncheon, banquet, and prizes (\$10.00).

I would also like room reservations for Sunday night, July 18. Number of Persons.....

Twin Double

Please check: New Member Old Timer

Mail To: R. W. Elwell, Secretary
Academy of Medicine
1420 Monroe Street
Toledo 2, Ohio

MAKE CHECKS PAYABLE TO OHIO STATE MEDICAL GOLFERS' ASSOCIATION

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT IS BEING DONE IN YOUR AREA ON 25-POINT PROGRAM?

The New Jersey State Medical Society News Letter recently made this observation:

"In times past, medical societies have been known to formulate impressive programs, adopt elegant resolutions, publish their admirable intentions—and then file the whole business away."

This must not happen in Ohio.

The Ohio State Medical Association has a 25-point program. It is being followed up by the various committees of the State Association, but that isn't enough. It must be followed up locally by all County Medical Societies. Each point charts the way to real action.

What is your County Medical Society doing to make these points a reality in your community? What are you doing as an individual physician?

It's time to find out—and to get busy.

WHEN YOU MAKE A SPEECH, TALK IT, DON'T READ IT

When you have to make a speech, talk it, don't read it.

"Being handcuffed to a manuscript generally means making a monotonous talk," advises one medical journal.

It's interesting to observe the reactions of an audience when a speaker begins his remarks. If he starts off by sticking his head into a manuscript, a large number of listeners immediately settle back with an attitude of "well, we have to take this punishment, so we might just as well relax and try to enjoy it." Not so when the speaker stands up and let's them have it without reading from a paper.

Try it, the next time you orate.

OHIO BEING TAKEN FOR A RIDE

According to the Federal Security Agency, the State of Ohio received Federal hand-outs totaling \$67,723,000 during the fiscal year which ended June 30, 1947, for health, education, welfare, vocational rehabilitation, and social security activities and benefits.

Put that in your pipe and smoke it!

And, don't forget that the piper calls the tune.

Also, don't forget that what Ohio got back is only a relatively small part of what it paid in through taxes which were nicked hard to help so-called poor states and for administrative

costs at Washington. In addition it gave away a lot of control over its own affairs.

Those forefathers who fought for states' rights and against central government dictatorship certainly must turn over in their graves a good many times in these times.

By continuing to accept Federal hand-outs for activities which it can and should finance and control itself, Ohio is merely playing into the hands of those who are hoping to keep in the saddle those who believe they have some peculiar right or ability to run other people's business.

CONSTRUCTIVE WORK IN COLUMBIANA COUNTY

What has been described as "a practical and successful rural health survey", was conducted recently in Columbiana County, where enumerators were assigned to survey conditions among their immediate neighbors.

Credit for instigation and organization of the survey went to the county agricultural agent who offered the facilities of the extension service for the purpose, while the mainstay of the survey was Dr. B. B. McGuire, county health commissioner. Success of the undertaking rested in the fact that the help of practically all organizations and groups interested in rural and farm life was enlisted.

Enumerators were assigned 20 farm families each in their immediate communities, and, according to reports, met with high degrees of cooperation from heads of families. Results of the survey were scheduled to be tabulated at the Youngstown College. The results will not be made public, it was announced, but will be made available for educational purposes.

Information sought included: Immunizations among members of rural families; presence or history of tuberculosis, cancer or communicable diseases; uncorrected physical defects; sanitary conditions on farms, such as pollution of sources of drinking water; number of families protected by prepaid hospital insurance policies; distance to nearest hospital and family doctor; and number of days of school missed by children with the reason for their absence.

Another similar survey is to be conducted two years hence in order to determine what progress will have been made after health interest has been stimulated by the original project.

The program in Columbiana County is a typ-

ical example of democracy in action. The farm people there did not stand on the sidelines, waiting and hoping for some super state or Federal agency to do a job which they wanted done. They did it themselves. The good work which has been done there can, and should, be duplicated in many other areas.

Here is a chance for each County Medical Society to do some real public relations work, in addition to aiding in a constructive program of health education. Working together, the medical society and the rural organizations in any county can do a valuable piece of work, like that done in Columbiana County.

COURT DECISION MAY STOP "DANGEROUS DRUG" SALES

A recent decision of the U. S. Supreme Court may have an important bearing on curtailment, perhaps elimination, of sales of dangerous and habit-forming drugs by druggists without prescription, providing, of course, the enforcement machinery operates effectively.

The court ruled that the Federal Food, Drug and Cosmetic Act covers retail sales made in intrastate commerce, if the drug has been shipped in interstate commerce any time prior to the retail sale; also that "misbranding" a drug includes taking it from a properly labeled bottle and selling it in an unlabeled container. The case in question arose when a Columbus, Ga., druggist bought a bottle of sulfathiazole tablets from the Atlanta, Ga., warehouse of a manufacturer. The tablets had been originally shipped from Chicago by the manufacturer. The druggist resold the tablets, removing them from the properly labeled bottle and placed them in a box which did not contain the directions for use, or warnings of danger, required by law.

Commenting on the decision, the *Ohio State Pharmaceutical Association Bulletin* offered this advice to its members:

"Now that the highest Court in the land has ruled that the Federal Food, Drug and Cosmetic Act can be applied to retail sale or sales made in intrastate commerce, it would appear that the retail pharmacist should take cognizance of the rules, regulations, and opinions of the Federal Food and Drug Administration with respect to sale of drugs and devices deemed dangerous and habit-forming which are to be sold only on prescription as well as the labeling and warning requirements of the law. While we have always advocated a policy of law compliance and adherence to the FDA rules and regulations, we are aware of the fact, based upon reports, that not all retail pharmacists require a prescription for barbiturates, sulfa drugs, etc., therefore, the matter of competition becomes a factor in the loss of such sales. Possibly organized pharmacy has now reached the point where strict enforcement of the law should be requested, not only for the

protection of the public but also to gain more respect for the law by the pharmacist who has obeyed the law in the past. We still insist the pharmacist assumes a potential liability in the sale of dangerous and habit-forming drugs without a prescription. Local drug associations should discuss the effect of this decision on over-the-counter sales by their members in their trade areas because the FDA, armed with this Supreme Court decision, may now start a "crack-down" enforcement program. It is generally believed that some physicians are more guilty than pharmacists in the promiscuous dispensing of dangerous and habit-forming drugs."

The final statement of the above quotation may be debatable. Nevertheless, it is a fact that some physicians have been supplying dangerous and habit-forming drugs to individuals promiscuously. This practice should be stopped. Unless it is, restrictive legislation will surely be enacted, and any such law might interfere with the freedom of the physician to use his good judgment in justifiable cases. Also, this practice puts the physician in the position of contributing to the mental and physical downfall of those who can be salvaged through proper therapy.

MORE GRIEF AS RESULT OF BONER BY N. P. C.

Did you ever have the experience of having your best plans and intentions knocked into a cocked hat because of the blundering tactics of some self-appointed butterinsky?

That's exactly what has happened with respect to one phase of the public relations program of the medical profession.

Real efforts have been made by national, state, and local medical societies to develop a closer relationship with the press—especially the editors, managing editors, and city editors of local newspapers, realizing that they can be potent allies in providing the public with sound and proper information on medical and health questions and on the economic, social, and legislative aspects of medicine and health.

Unfortunately the crude tactics of the National Physicians Committee have undone much of the good which medical societies have been able to accomplish. As pointed out in the May issue, the so-called cartoon contest which *Editor and Publisher* lambasted is the most notable recent example.

The N. P. C. has the gall to claim that the fuss stirred up by *Editor and Publisher* and a good many newspapers, who charge an attempt to "bribe" cartoonists, "has multiplied by ten the effectiveness" of the cartoon contest.

Judging from the following editorial in the May 15 issue of *Editor and Publisher* and a piece written in the *Newark (O.) Advocate*, the

newspaper fraternity thinks otherwise and, in our opinion, its views should not be given the brush-off by the medical profession:

ON THE SPOT

"'If your local newspaper blossoms out with some biting cartoons between now and May 31, attacking national health insurance and other proposals for extending the benefits of medical care, don't attribute it solely to the anti-social viewpoint of the cartoonist, or of the newspaper. It may well be that the poor cartoonist is only trying to earn an extra \$1,000 in a contest sponsored by the peculiarly misnamed National Physicians' Committee for the Extension of Medical Service.'—from *Consumer Reports*, May, 1948.

"In our first editorial attacking this cartoon contest (March 6), *Editor & Publisher* said: 'It will be difficult for any cartoonist or his editor to deny the charges of the critics that they were bribed by the \$1,000 first prize into supporting the viewpoint of the N.P.C. even though their opinion may have been arrived at independently.'

"The nation's cartoonists have been put on the spot. They can't editorialize on this particular subject, though they may be unaware of the contest, without having someone charge they were bribed into adopting that viewpoint.

"On the other hand, the National Physicians' Committee has injured its own cause. Many editors and cartoonists might have opposed national health insurance if left to their own devices. Now they are staying away from the subject, with few exceptions."—*Editor and Publisher*.

* * * *

MEDICOS PULL BONER ON QUESTION OF ETHICS

By Frank Tripp

A committee of doctors diagnosed their own case and now have a bear by the tail. They tried self-medication for their public relations ills with dire results.

The row has to do with ethics. The groups involved are not all-inclusive of either doctors or newspapermen. They are sort of special groups of each who are having it out in their inner councils and trade press.

It all started when the National Physicians' Committee "for the extension of medical service" got a bright idea. It was a roundabout, impersonal way to conduct a country-wide publicity crusade against socialized medicine.

Time was when the mere suggestion that doctors craved publicity would have roused the animals. Chartered trains, of troop transport dimensions, would have rushed from advertising headquarters to any spot in the Mohave desert, if doctors would even discuss so unethical a device as publicity.

But this time the mountain went to the Mohammed. With prizes and everything—and an idea that belongs in the soap business. They offered a \$1,000 prize to the cartoonist who would produce the best pictured argument against socialized medicine.

The men whose caricatures make millions think were insulted. That one grand could start no special riot among them was not the issue. Some of them drop that much on every trip to the bookies.

If the insult—"and methinks a tiny one," as Poo Bah did proclaim—had come from a profession less steeped in ethics, no doubt it would have reached wastebaskets with no more scolding

than do the daily offerings of average press agents.

The well-intentioned doctors, who declare so much on their side against public health care, put their foot right in it. They killed bales of voluntary argument in their behalf and scared off top flight artists who might have gone all out for their cause if there had been no prize involved.

What the ethical knights of the stethoscope overlooked was that there also are such things as newspaper ethics. They, and you, may never have heard of them but they do exist and, when they're stirred up, a hornets' nest is as docile as a puff ball in comparison.

You see, the offered prize amounted to a bribe, the cartoonists thought; an offer to buy the power of their art and the editorial space which their drawings occupy. Most editors and publishers agreed with them. They all said so, and the row was on.

Some editors who might be as anti-socialized medicine as is the doctors' committee have even tabooed the topic in their columns, lest their readers think their editorial attitude can be influenced by a prize.

Thus somebody's cute idea went upon the rocks and another important group of intelligent people came to know that ethics are not confined to medicine, clergy, the law or plaques that hang on office walls.

As old as medicine, is the tenet of the reputable writer that his editorial integrity cannot be bought; that it must not be placed in jeopardy; that he will defend the sincerity of his words against suspicion.

There are no oaths of allegiance, no proclamations of ethical standards in editorial offices and news rooms. But there are robust, unwritten principles by which one practitioner judges another.

These men deal in thoughts, which they put on paper and release to the world. Sometimes they are hired to express another's thoughts. Then the other sponsors what they write. In this they may not always relish their task; no more than does a surgeon who keeps a public enemy alive.

As with all professionals, their work oft puts them in a light that's little understood. But when they speak their own minds, whether under their names or upon pages entrusted to their judgment and care, none but a rare skunk among them can be had for any price—sugar-coat the potion as you will.

None of them wants to become a thought abortionist.—*Newark (O.) Advocate*.

COUNTY SOCIETY MAKING RECORDINGS OF TALKS

The Sandusky County Medical Society is trying a stunt which sounds mighty good and is recommended to other societies for their consideration.

The society is making wire recordings of medical addresses made before the society. At the end of the year, the recordings will be used at a symposium or perhaps printed for distribution to members.

We don't know which member of the Sandusky County Medical Society had this happy idea but whoever he is, he deserves commendation.

**ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE
OHIO STATE MEDICAL JOURNAL FOR YEAR ENDED DECEMBER 31, 1947, BY
KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC
ACCOUNTANTS, COLUMBUS, OHIO**

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand at January 1, 1947:

Cash in Huntington National Bank	\$ 11,444.69
Cash in Ohio National Bank (1947 Member- ship dues)	38,415.00
United States Treasury Bonds	20,000.00
Total cash and bonds on hand, January 1, 1947	\$ 69,859.69

RECEIPTS

1947 Membership dues collected in 1947	\$ 66,470.00
1948 Membership dues collected in 1947	53,565.00
Interest on United States Treas- ury Bonds	750.00
Exhibit Space for 1947 Annual Meeting	9,204.50
Exhibit Space for 1948 Annual meeting	3,195.00
Banquet Tickets sold at 1947 An- nual Meeting	3,215.00
A.M.A. Meeting Expense reim- bursed	500.00
Refund on automobile insurance premium	4.28
Payment stopped on two checks, reissued	6.00
Total receipts	\$136,909.78
U. S. Bonds Purchased in 1947	\$ 45,000.00
Total To Be Accounted For	\$251,769.47

DISBURSEMENTS

The Ohio State Medical Journal	\$ 10,000.00
Executive Secretary Salary	8,200.00
Executive Secretary Expense	844.01
President, Expense	542.35
Committee on Public Relations and Economics	837.07
Dept. of Public Relations: (\$12,846.07):	
Director, Salary	6,700.00
Director, Expense	1,230.68
Literature	2,787.76
Radio and Newspapers	60.87
Exhibits and Movies	293.45
Postage and Supplies	1,773.31
Retirement Fund	2,272.89
Stenographers, Salaries	10,112.50
Council, Expense	1,476.24
A.M.A. Delegates, Expense	1,472.38
Committee on Cancer	70.43
Committee on Education	718.57
Committee on Industrial Health	6.50
Committee on Medical Care of Veterans	371.12
Committee on Medical Service Plans	425.72
Committee on Rural Health	19.78
Committee on Scientific Work	571.53
Miscellaneous Committees	40.11
Annual Meeting	13,343.58
Conference County Society Presi- dents-Secretaries	767.31
Remodeling Offices	4,906.02
Stationery and Supplies	1,419.21
Postage, Telephone, and Telegraph Rent	2,590.29
Auditing	4,691.00
Employees' Position Bonds	100.00
Industrial Insurance	30.00
Unemployment Insurance	13.54
Automobile Liability and Prop- erty Damage Insurance	123.25
Fire and Burglary Insurance	133.72
Safety Deposit Box Rent	60.06
Woman's Auxiliary to Ohio State Medical Association	3.60
Checks Reissued	200.00
Dues Refunded—1946	6.00
Dues Refunded: military—one; deceased—two	7.00
Dues Refunded—Overpayments	45.00
	44.00

Purchase of U. S. Treasury Bonds	20,000.00
Accrued Interest on Bonds to date of purchase	111.26
Premium and commission on Bonds purchased	635.00
Purchase of U. S. Savings, Bonds, Series G	25,000.00
Total disbursements	\$125,057.11

Cash on Deposit and Bonds on Hand: December 31, 1947:

Huntington National Bank	\$ 8,147.36
Ohio National Bank	53,565.00
U. S. Savings Bonds, Series G	45,000.00
U. S. Treasury Bonds, Series of 1967-72	20,000.00
Total cash and bonds on hand December 31, 1947	\$126,712.36
Total Accounted For	\$251,769.47

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Balance Sheet at December 31, 1947

ASSETS

Current Assets:	
Cash in Ohio National Bank	\$ 1,885.83
Petty Cash	10.00
Total Cash	\$ 1,895.83
Accounts Receivable:	
Advertising	1,722.68
Prepaid Travel Expense	500.00
Hospitalization and Ohio Med. Ind. Premiums	30.30
Bank Charge	1.28
Total current assets	\$ 4,150.09
Property Assets:	
Furniture and Fixtures (depreciated value)	8,442.51
Total Assets	\$ 12,592.60

LIABILITIES AND SURPLUS

Current Liabilities:	
Subscriptions Prepaid	\$ 150.00
Advertising Prepaid	2.50
Total Liabilities	\$ 152.50
Surplus:	
Surplus at December 31, 1946	\$11,542.42
Add Net Income for the Year 1947	897.68
Surplus at December 31, 1947	12,440.10
Total Liabilities and Surplus	\$ 12,592.60

STATEMENT OF PROFIT AND LOSS

Revenue:	
Advertising	\$ 32,788.04
Less:	
Commissions on Advertising	\$ 1,923.31
Cash Discount on Advertising	936.94
Advertising Revenue, Net	\$ 29,927.79
Circulation	10,197.65
Membership Subscriptions	400.00
Total Revenue, Net	\$ 40,525.44
Expenses:	
Journal Printing	\$27,333.37
Salaries	8,500.00
Traveling Expense	323.25
Journal Postage	832.98
Journal Illustrations and Engraving	328.78
Depreciation	651.54
Clipping Service	180.00
Dues and Subscriptions	281.23
Stationery, Printing, Supplies	876.33
Miscellaneous Postage and Expense	320.28
Total Expense	\$ 39,627.76
Net Income for the Year	\$ 897.68

In Memoriam

Richard Sisson Austin, M. D., Cincinnati; Harvard Medical School, 1911; aged 63; died April 30; member of the Ohio State Medical Association and Fellow of the American Medical Association; President of the Cincinnati Academy of Medicine in 1938; member of the American Association of Pathologists and Bacteriologists, and the American Society for Experimental Pathology. Dr. Austin was professor of pathology at the University of Cincinnati College of Medicine and director of pathology service at General Hospital. He had been on the University's faculty since 1928. He was a former president of the Public Health Federation, vice-president of the Cincinnati Board of Health, vice-president of the P. H. F., and president of the local chapter of Sigma Xi. Surviving are his widow and a sister.

Edmond Elmore Bohlender, M. D., Dayton; Medical College of Ohio, Cincinnati, 1894; aged 80; died April 26; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1946; and second vice-president of the Montgomery County Medical Society in 1918. Dr. Bohlender practiced medicine in Dayton for 52 years and retired from active practice only two years ago. He was an elder in the Presbyterian Church, a member of several Masonic orders, Knights of Pythias, and the Triangle Club. Surviving are his widow, two daughters, two sons, including Dr. George P. Bohlender of Erie, Pa., and two sisters.

William O. Bonser, M. D., Toledo; University of Toronto Faculty of Medicine, 1911; aged 59; died April 22; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Bonser had actively practiced in Toledo since the completion of his medical education. He was a member of the staffs of Maumee Valley, Mercy, and Toledo State Hospitals. He was active in several Masonic orders. Surviving are his widow, his mother, a son, Dr. William H. Bonser, also of Toledo, and two sisters.

Lyman W. Childs, M. D., Cleveland; Western Reserve University School of Medicine, 1894; aged 80; died April 24 in Fort Lauderdale, Fla.; former member of the Ohio State Medical Association and the American Medical Association through 1935. Dr. Childs for 17 years was supervisor of public health in Cleveland schools and at one time was a member of the Chamber of Commerce's sanitation committee. In 1930 he was president of the American Association of School Physicians. Surviving are his widow, a son and five daughters.

Murray Nathan Fowler, M. D., Mansfield; University of Toronto Faculty of Medicine, 1923; aged 49; died April 29; member of the Ohio State Medical Association and the American Medical Association, and a member of the American Psychiatric Association. Dr. Fowler was psychiatrist at the Ohio State Reformatory since 1941 and for 13 years had been on the staff of the Athens State Hospital. He also had been superintendent of the State Institution for the Feeble-minded at Apple Creek. He served with the Medical Corps in the Mediterranean Theater during World War II and was discharged in the grade of major. He was a member of the Masonic Lodge.

Myron Hopkins Powelson, M. D., Zanesville; Ohio State University College of Medicine, 1926; aged 44; died May 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Powelson had practiced medicine in Zanesville since 1930. He was a member of the several Masonic orders and of the Elks Lodge. Surviving are his mother, his son, Myron H. Powelson, Jr., a student in the University of Louisville School of Medicine, a brother, Dr. Harry Powelson, also of Zanesville, a daughter and a sister.

Andrew Walter Prout, M. D., Columbus; Ohio State University College of Medicine, 1909; aged 63; died April 14; member of the Ohio State Medical Association and the American Medical Association, also a member of the American Academy of Ophthalmology and Otolaryngology. Dr. Prout had practiced medicine in Columbus for approximately 40 years. He was a member of the Columbus Club, the Columbus Country Club, the Columbus Riding Club, and Phi Delta Theta and Nu Sigma Nu fraternities. Surviving are his widow, three sons, a sister and a brother.

Raymond Jesse Seymour, M. D., Columbus; Ohio Medical University, Columbus, 1904; aged 69; died April 10. Dr. Seymour was on the medical faculty of Ohio State University College of Medicine for 42 years where he was professor of physiology until his retirement in 1945. He was a member of the Congregational Church. Surviving are his widow, a son, Dr. Miner D. Seymour, also of Columbus, his mother and a sister.

Floyd Rodman Stamp, M. D., Alliance; Tufts College Medical School, Boston, 1912; aged 66; died April 27; former member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Stamp practiced medicine in Alliance from 1916 until his retire-

ment in 1947 and served as Stark County health commissioner for approximately 17 years. He was a member of the Elks Club and a former member of the Rotary Club. Surviving are his widow, a son, a daughter and two brothers.

John James Thomas, M.D., Cleveland; Western Reserve University School of Medicine, 1893; aged 79; died April 15; member of the Ohio State Medical Association and the American Medical Association, and a past-president of the Cleveland Academy of Medicine. Dr. Thomas began to teach at Western Reserve University School of Medicine in 1898, in 1935 became associate professor of obstetrics and recently was designated associate clinical professor emeritus in obstetrics. He was on the staffs of St. Ann's, Maternity, Women's and St. Alexis' Hospitals. From 1911 to 1914 he was a member of the Board of Health and from 1920 to 1940 was president of the Cleveland Milk Commission. He was a past-president of the City Club and of the Citizens' League and a member of the Professional Club of Cleveland. Surviving are his widow and a son.

Luther Brown Turner, M.D., Columbus; Starling Medical College, Columbus, 1892; aged 85; died April 23; former member of the Ohio State Medical Association and the American Medical Association through 1946. Dr. Turner practiced medicine in Columbus since 1908 and was active until the time of his death. He was a member of the Methodist Church, was active in Masonic orders and was a member of the Knights of Pythias. Surviving are a daughter and two sons.

Kensley Scott West, M.D., Cleveland; Ohio Medical University, Columbus, 1903; aged 74; died April 23; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1945. Dr. West began practice in Cleveland in 1903 and for 30 years was county psychiatrist in the Probate Court. He was formerly medical director of the Brotherhood of Railroad Trainmen and was a staff member of St. John and City Hospitals. He was a former member of the Westwood Country Club, the Cleveland Athletic Club and the Cleveland Rotary Club. He was a member of the Ohio State Alumni Association and was active in several Masonic orders. Surviving are his widow, a daughter and a sister.

Confidence Men Gyp Doctors

Physicians are warned of the recent presence in Ohio of two confidence men posing as physicians. Police reported that one man was posing as a physician and the other as an interne. After discussing medical matters, they suddenly discover they are short of cash for travel expenses and persuade their victim to cash a check.

Ohioans Invited To Join Western Tour After A.M.A. Meeting

The Oklahoma State Medical Association announces through Dick Graham, Executive Secretary, that it will sponsor a Post-Convention Tour in conjunction with the A.M.A. Convention which is to be held this year at Chicago, June 19 to 25, and extends a special invitation to the physicians and wives of Ohio to join Oklahoma physicians on their trip to the Canadian Rockies.

This 13-day tour is all-expense and starts from Chicago on Friday, June 25, at 1:15 p. m. at the close of the A.M.A. Convention. They will visit Jasper National Park, Columbia Icefield, Lake Louise, Banff, as well as spending one day at the Calgary Stampede before returning back to Chicago on July 7. The trip includes the choice of menu, finest hotels, Pullman accommodations, as well as complete sightseeing program. All transfers and baggage handling are also included. The tour will be under the personal direction of Mr. Harry E. Kornbaum who has conducted the two previous Oklahoma Medical Association Tours, last year to Quebec and the previous year to San Francisco and the Pacific Northwest.

This tour will be a special train and limited to 130 reservations. Pullman accommodations will be assigned in order of reservations received. For those who are interested, write direct to Mr. Dick Graham, Executive Secretary, Oklahoma State Medical Association, 210 Plaza Court, Oklahoma City, Oklahoma. A complete day by day itinerary with prices will be forwarded.

Doctors Orchestra of Akron To Complete 22nd Season

The Doctors Orchestra of Akron is scheduled to end its 22nd Season on June 2 with a dinner and its 127th concert at the Women's City Club, Akron. It is the oldest orchestra in the city, its conductor affirmed.

Founded in November, 1926, the Orchestra has carried on without a break, even during the war when 32 per cent of its members were in the armed services. A member of the group pointed out that while five symphony orchestras have been organized in Akron since 1926, all of the others have disbanded.

The orchestra gave its first out-of-town concert in Columbus on May 10, 1927, before the Annual Meeting of the Ohio State Medical Association. It has given concerts in 11 cities and towns of Ohio for 25 organizations, most of them hospitals and medical and dental societies. The 23rd season will open in December.

The conductor is Dr. A. S. McCormick, and the concert master, Dr. Arthur Dobkin. They with Dr. R. E. Pinkerton form the executive committee. The present membership is 34.

Do You Know? . . .

Dr. A. Carlton Ernstene, Cleveland, was one of the guest speakers at the 89th Annual Session of the Kansas Medical Society, May 10-13, at Wichita. He spoke on "Hypertension" and "The Treatment of Congestive Heart Failure" at general sessions and participated in a round-table discussion on "Heart."

* * *

A recent survey of the American College of Surgeons indicated that 82 per cent of more than a thousand hospitals were already utilizing adjunct nursing personnel, and 60 per cent favored the establishment of training facilities for nurses' aides within their own walls.

* * *

Current national legislation in the field of health and the constructive program of the medical profession for better health for all the people were explained by George H. Saville, Director of Public Relations, Ohio State Medical Association, at meetings of the Urbana Lions Club, May 5, and the Dayton Northridge Kiwanis Club, May 6.

* * *

The people of Byesville in Guernsey County turned out en masse recently for a party in the high school auditorium honoring Dr. James E. Patton who has been practicing in the community since 1904. He was presented with a medicine case as a token of appreciation.

* * *

Guest speakers at the 81st Annual Meeting of the West Virginia State Medical Association, May 10-12, at Huntington, W. Va., included Dr. Henry W. Goodyear, Cincinnati, who discussed "Some Practical Considerations in the Use of Chemotherapy and Antibiotics in the Treatment of Upper Respiratory Infections," and Dr. Russell L. Haden, Cleveland, who spoke on "Gout."

* * *

Ninety-five out of 100 applicants for life insurance obtain policies, according to a report issued by the Institute of Life Insurance. An analysis of one year's applications of companies representing approximately one-half of all ordinary life insurance purchased shows that 95 per cent of the applicants received policies, 85 per cent at standard rates and 10 per cent at extra rates.

* * *

Members of the medical profession in Philadelphia where the Republican and Democratic National Conventions will be held in June and July, have organized a group of prominent physicians who will be available on a 24-hour emergency service to delegates, alternates, and other officials of the conventions. It is planned

to have an office in the central headquarters, also in Convention Hall.

* * *

The contract for the construction by the Veterans Administration of a 200-bed hospital at Grand Island, Neb., has been awarded on a low competitive bid of \$5,244,854, approximately \$26,000 per bed.

* * *

Dr. George M. Curtis, Columbus, spoke on "The Treatment of Hyperthyroidism" during the annual meeting of the Illinois State Medical Society at the Palmer House, Chicago, May 10-12.

* * *

Athens, Vinton, and Hocking County health departments have been merged into a single health district. Dr. H. G. Southard, Logan, Hocking County health commissioner, will head the combined district.

* * *

Three Darke County physicians, each of whom has rounded out a half-century of active practice, have been elected to honorary membership in the Darke County Medical Society. They are: Dr. Wm. C. Gutermuth, Versailles; Dr. O. P. Wolverton, Greenville; and Dr. O. P. Kimmel, New Madison.

* * *

In 1941, there were 5,256 residencies in approved hospitals in the United States. Today, there are 15,172.

* * *

Col. Frank E. Hamilton, formerly of Columbus, chief of the surgical service, Walter Reed Hospital, Washington, D. C., was one of a team of consultants sent to Europe in March for a tour of Army hospitals in order to facilitate advanced medical training of medical officers overseas.

* * *

A constitutional amendment proposed in California would authorize and direct the state legislature to establish a system of health and hospital insurance for the people of that state. Dental care and routine periodic physical check-ups would be included in the proposed program.

* * *

Dr. Charles F. McKhann, professor of pediatrics, Western Reserve University School of Medicine, Cleveland, spoke on "Chronic Malnutrition in Children" during the annual meeting of the Tennessee State Medical Association, April 13-15, at Nashville.

* * *

According to the *Detroit Medical News*, doctors of medicine prescribe about 15 per cent of the eyeglasses that are worn; 85 per cent are prescribed by optometrists and others.

Ohio Academy of General Practice Announces Progress

The Ohio Academy of General Practice is progressing at a rapid rate in completing its organization, according to an announcement received from Dr. Joseph Lindner, of Cincinnati, president. The Officers and Directors have met at frequent intervals and are nearing completion of details. The committee member roster has been completed. It was the policy of the Board of Directors to place on committees only individuals who agreed to accept the responsibility of committee work and expressed their willingness to give their full cooperation, Dr. Lindner said.

Dr. Lindner pointed out that the general scheme of organizing the American physician doing general practice is from the top down. The American Academy of General Practice is composed of individual State Academies of General Practice and these in turn are made up of individual County (or groups of counties) Academies of General Practice.

A plan for the formation of logical component or local groups of the Ohio Academy of General Practice has been adopted. These organizations are being formed in each district by a district organizer. Already two districts have virtually completed their local organization work and the remaining nine districts will soon achieve their goal, Dr. Lindner announced.

The district organizers are as follows: District (1), Neil Millikin, M.D., 610 Main Street, Hamilton; District (2), Gordon L. Erbaugh, M.D., 2156 East Third Street, Dayton 3; District (3), J. R. Jarvis, M.D., Van Wert; District (4), Roscoe H. Snyder, M.D., 15 Bronson Place, Toledo 8; District (5), Herbert W. Salter, M.D., 5005 Euclid Avenue, Cleveland 3; District (6), Emery G. Kyle, M.D., 15 North Canal Street, Newton Falls; District (7), Carl F. Goll, M.D., Hopedale; District (8), Paul C. Grove, M.D., 75 North Second Street, Newark; District (9), H.D. Chamberlain, M.D., McArthur; District (10), Percy B. Wiltberger, M.D., 350 East State Street, Columbus 15; and District (11), Ross M. Knoble, M.D., 165 East Washington Row, Sandusky.

Any Ohio physician who is interested in becoming a member of organized general practice may do so by contacting his local Academy of General Practice or his district organizer.

NINTH DISTRICT MEETING

There will be a meeting of general practitioners of the Ninth District of the Ohio State Medical Association on Thursday, June 17, at the Chambrian Hotel, Jackson, to organize a chapter of the Academy of General Practice in the district. Dinner will be served at 6 p.m. for those

who wish it and the regular meeting will begin at 8 p.m. Those intending to be present for dinner are requested to notify Dr. H. D. Chamberlain, McArthur.

Army Launches Program To Procure 520 Physicians

The first of the Army Medical Department Procurement Programs is now ready for implementation. This program is the one in which 520 physicians will be tendered appointments in the Regular Army Medical Corps during 1948 and may compete for 260 residencies in military and civilian hospitals. The announcement came from Col. John E. McMahon, Jr., Fort Hayes, Columbus, executive officer of the Ohio Military District.

Phase I will commence on July 1, 1948, and will be followed in January and July of 1949 with Phases II and III, respectively.

For Phase I, 60 residences in Army hospitals have been allocated in urology, anesthesia, orthopedics, dermatology, internal medicine, pathology, ophthalmology, otolaryngology, radiology, tuberculosis, cardiology, and physical medicine.

It is the intent of the Surgeon General to commission 120 physicians in the Regular Army Medical Corps to compete for this training. Only those who have completed their period of obligatory service prior to Sept. 1, 1948, including those already separated, are eligible to apply. The number of residencies filled will be 50 percent of the number of physicians commissioned for competition, but the total will not exceed 60.

Those persons who are selected will be permitted to enter residency training in an A.U.S. status. Failure, however, to accept a Regular Army commission, when tendered, will be cause for removal from the program.

Resignation of officers who have been commissioned under this phase of the program will not be accepted within one year after date of the commission. Those who are accepted for residence will be required to serve on a duty status for a period of time equal to that spent in formal training.

These are some of the considerations which are used to determine grade appointment: the applicant's age; active professional service, excluding internship, but including residencies and postgraduate training.

Application blanks or information may be obtained from Headquarters Ohio Military District, Fort Hayes, Columbus 18, Ohio.

Plans for a \$2,000,000 cancer research hospital in Cincinnati were announced recently by Msgr. Cletus A. Miller, president of the Institutum Divi Thomae.

Buckeye News Notes

Amherst—Dr. John L. Sullivan Elyria, was principal speaker at a recent meeting of the Amherst Rotary Club. His talk was on cancer.

Amherst—Dr. D. A. Russell, Lorain, recently was principal speaker before the Amherst Junior Chamber of Commerce. He spoke on the subject of "Cancer, Our Common Enemy."

Bellevue—Dr. H. R. Dewey recently celebrated his 50th anniversary in the medical profession.

Canton—Dr. William B. Bean, University of Cincinnati College of Medicine, recently addressed the Canton Rotary Club, discussing the promiscuous use of vitamin pills by the public.

Canton—Dr. John D. O'Brien recently was re-appointed as a member of the advisory council to the Mental Hygiene Division of the Public Welfare Department of Ohio.

Columbus—The first Alumni Achievement Award of the Ohio State University College of Medicine was presented recently by Dr. Charles A. Doan, dean, to Dr. Verne A. Dodd, professor in the department of surgery at O. S. U. and chief of staff of University Hospital, and Dr. Robert A. Moore, dean of the Washington University School of Medicine, St. Louis.

Columbus—Dr. George H. Ruggy, junior dean of the Ohio State University College of Medicine, recently was guest speaker for the Monday Talks. His subject was "Recent Advances in Medical Science."

Coshocton—Dr. J. F. Lake, Dover, spoke on "Alcoholics Anonymous" before a meeting of the Business and Professional Women's Club.

Crestline—Dr. J. B. Moses, after 50 years of medical practice in the community, moved to Cincinnati where he and Mrs. Moses will make their home.

Dayton—Dr. Calvin L. Baker, formerly clinical director of Columbus State Hospital, on May 1 became superintendent of the Dayton State Hospital. He succeeds Dr. E. L. Hooper who resigned to become assistant chief of the neuropsychiatric section of the Veterans Administration, Sixth Ohio District.

Dover—Dr. Thomas S. McGough is the new Tuscarawas County health commissioner, beginning June 1.

Lorain—Dr. Joseph M. DeNardi was speaker at a recent meeting of the Lorain Business and Professional Women's Club.

Mansfield—Four Mansfield doctors with 50 or more years of medical service were honored re-

cently by fellow physicians. Dr. Robert R. Black, Dr. J. M. Garber, and Dr. J. L. Stevens were honored at a recent dinner. Dr. J. A. Yoder, the fourth doctor, was in Florida at the time. Dr. Roy W. Scott, of Cleveland, was guest speaker for the occasion.

Mt. Sterling—Dr. R. W. E. Irwin has completed 50 years of active medical practice.

Springfield—Dr. E. H. Long of South Vienna was appointed to the Clark County Sanatorium Board of Trustees for a three-year term. He replaces Dr. A. K. Howell, of Springfield.

Toledo—Three members of the class of 1898 of the former Toledo Medical College held a recent reunion. They are Dr. Arthur J. Richie, Dr. George H. Jones, and Dr. James A. Coleman.

Wapakoneta—Dr. William K. Bannister of Lima was principal speaker at a recent meeting of the Auglaize County Tuberculosis and Health Association.

Williamsburg—Dr. Carl Minning was elected president of the General Grant Chapter of the Reserve Officers Association.

Worthington—Dr. Warren G. Harding was one of 14 Americans decorated by the Chinese Government for services to that country. Dr. Harding was superintendent of the Sydney (Australia) Sanitarium during the early part of the war.

Folks in 17th District Against Socialized Medicine

Ninety-five per cent of a cross-section of citizens in the 17th Ohio Congressional District are opposed to legislation placing the medical and dental professions under Federal control, according to a recent survey conducted by Representative J. Harry McGregor, Republican, West Lafayette.

Congressman McGregor, who conducts such surveys in his district from time to time, sent out 2,800 questionnaires on various questions of current public interest, and received 1,600 replies.

Medicine a la Wallace

One of the planks in the nine-point platform announced by Henry A. Wallace, Third Party candidate for president, as reported by one of the press services, reads as follows: "\$100 a month old-age insurance, \$1 an hour minimum wage, and protection of health with practical form of socialized medicine for the benefit of all the people."

Licensed Through Endorsement by State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through endorsement of their licenses to practice in other states:

January 6, 1948—Edgar V. N. Allen, Cleveland, Univ. of Nebraska; Arthur P. Daniel, Tiffin, St. Louis Univ.; Devitt L. Gordon, Akron, Univ. of Michigan; Gloria Hilker, Kent, Univ. of Illinois; Stephen P. Hogg, Cincinnati, Univ. of Louisville; Thomas C. Jones, Columbus, Meharry; Edgar R. Kyger, Jr., Cleveland Heights, Univ. of Pennsylvania; Stanislaus J. Makarewicz, Columbus, Georgetown; Neil C. Perkins, Dayton, Duke Univ.; Stanley B. Peters, Kent, Univ. of Rochester; Alfred E. Rhode, Toledo, Univ. of Vienna; Robert J. Roehm, Lakewood, St. Louis Univ.; Edmund Rothfeld, Cincinnati, Univ. of Lausanne; Jack H. Welch, Columbus, Duke Univ.

April 6, 1948—Alfons R. Altenberg, Dayton, Northwestern Univ.; Reid H. Anderson, Cleveland, Duke Univ.; Mathew B. Arnoult, Columbus, Univ. of Tennessee; William E. Askue, Toledo, Columbia Univ.; Frederick C. Badt, Cleveland, Univ. of Hamburg; William A. Blank, Toledo, Univ. of Nebraska; Daniel E. Brannen, Dayton, Jefferson College; Robert W. Buckley, Cincinnati, Boston Univ.; Eugene J. Burns, Cincinnati, Univ. of Louisville; James B. Campbell, Columbus, Harvard; Alfred E. Coodley, Cincinnati, Univ. of California; James A. DeJute, Niles, Univ. of Buffalo; Thomas E. Del Giorno, Akron, Long Island College; William S. Dempsey, Cleveland, Univ. of Vermont; Robert G. Fish, Toledo, Univ. of Michigan; William J. Gallo, Cleveland, Columbia Univ.; Jack B. Garlin, Bedford, Univ. of Oklahoma; Anita Peek Gilger, Cleveland, Johns Hopkins Univ.; William G. Gilger II, Cleveland, Johns Hopkins Univ.; Edward J. Glaser, Cincinnati, Loyola Univ.; John A. Grima, Warren, St. Louis Univ.

Arthur E. Hale, Columbus, Univ. of Oklahoma; Gabriel C. Heller, Columbus, Univ. of Szeged; Charles Henning Hendricks, Columbus, Univ. of Michigan; Frederick W. Hiss, Toledo, Univ. of Michigan; Willis H. Hodges, Jr., Columbus, Duke Univ.; Andrew T. Holiday, Cleveland, Univ. of Budapest; Herman F. Inderlied, Cleveland, Washington Univ.; Frederick W. Jarvis, Franklin County, Hahnemann; Clarence B. Johnson, Kent, Loyola Univ.; Eugene Kelemen, Massillon, Royal Hungarian Eliz. Univ.; William J. Kelly, Youngstown, St. Louis Univ.; Max Krakauer, Cincinnati, Univ. of Breslau; Gerald P. Lammers, Toledo, St. Louis Univ.; Leonard L. Lovshin, Cleveland, Univ. of Wisconsin; Jack Catlett Lunderman, Dayton, Vanderbilt.

Malcolm M. MacRae, Coshocton, George Wash-

ington Univ.; Charles S. McCulloch, Akron, Nebraska Univ.; Cornelius A. McGrew, Rittman, Univ. of Buffalo; Clifford McIntyre, Cincinnati, Columbia Univ.; Herbert R. Moore, Dayton, Univ. of Illinois; Thomas W. Morgan, Columbus, Harvard; Richard P. Mueller, Cleveland, Univ. of Michigan; Harold G. Nelson, Newark, Univ. of Kansas; Mervin B. O'Neil, Columbus, Univ. of Michigan; David W. Palmer, Columbus, Univ. of Maryland; Herbert L. Pariser, Columbus, Univ. of Michigan; Nathaniel C. Robey, Norwalk, Yale; Richard B. Schenk, Cleveland, State Univ. of Iowa; Eleonora Schmidt, Athens, Washington Univ.; Stanford D. Splitter, Cleveland, Univ. of Kansas; John Murray Summers, Springfield, Indiana Univ.; Robert E. Sumner, North Canton, Jefferson.

Harold E. Troup, Portsmouth, Univ. of Louisville; Samuel B. Vagner, Toledo, Meharry; Arthur L. Ventura, Dayton, St. Louis Univ.; Jack Vance Wallinga, Cleveland, Univ. of Minnesota; Robert St. C. S. Webbe, Columbus, Long Island College; Charles K. Winthrop, Akron, Duke Univ.

Dr. Forman Named to Forest Board

Announcement was made from Washington in May that Dr. Jonathan Forman, editor of *The Journal*, has been appointed by Secretary of Agriculture Anderson to the newly created National Forest Board of Review. Other appointees are Prof. G. B. MacDonald, Iowa State College, and Dr. Roland Renne, president of Montana State College.

Purpose of the three-member board is to advise the Department of Agriculture in regard to problems arising in connection with use by the public of national forests and other lands under control of the forest service. The problems have to do chiefly with grazing privileges.

COMING MEETINGS

American Medical Association, Annual Meeting, Chicago, June 21-25.

Aero Medical Association, 19th Annual Convention, Toronto, June 16-18.

American Academy of Pediatrics, Milwaukee, Wis., June 28-30.

American Congress of Physical Medicine, Washington, D. C., Sept. 7-11.

American Public Health Association, Boston, Mass., Nov. 8-12.

American Society for the Study of Sterility, Chicago, June 21, 22.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 8.

Ninth District Meeting of General Practitioners, Chambrian Hotel, Jackson, June 17.

Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, re-register with the Collector of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of \$1.00. Initial applications may be made at any time, but existing permits must be renewed on or before July 1, annually.

PENALTIES

Failure to re-register within the time allowed by law adds a penalty of 25 per cent to the annual tax, and in addition makes the physician liable to a fine not exceeding \$2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resultant publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

FORMS MAILED

Copies of the forms for re-registration are mailed by the District Collectors of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed.

Application for re-registration must be made on Form 678, signed by the physician applying, and either acknowledged by two qualified witnesses or sworn to by a Notary Public or an official of the Internal Revenue Department. The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. Remittance accompanying the application may be in the form of cash, a postal money order, or certified check. Personal checks not certified, will be returned to the sender.

INVENTORY NECESSARY

An inventory of the narcotic drugs on hand in the physician's office must accompany the application, on Form 713. The regulations require that this inventory must be sworn to by a Notary Public or an official of the Internal Revenue Department regardless of the quantity of drugs on hand.

Inventories may be taken at any time after the receipt of the application forms each year, and may be filed as soon as completed. They must be filed by July 1.

Physicians who administer, dispense, or pre-

scribe cannabis, must obtain a special permit under the Marihuana Tax Act, and re-register annually on or before July 1, with the Collector of Internal Revenue of his district, and pay a tax of \$1.00.

MUST APPLY AFTER MILITARY SERVICE

A physician in the armed forces need not re-register. If such a physician should receive an application form for re-registration he should return it to the office of the Collector of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

Transcriptions on Physical Medicine Available

The Bureau of Health Education of the American Medical Association in cooperation with the Council on Physical Medicine announced recently the distribution of electrical transcriptions devoted to phases of physical medicine. The series consists of 13 recordings, each of which will run for 14½ minutes.

This series, like others available, is loaned to local medical societies or for use in broadcasting projects approved by such societies. There is no cost except that borrowers are requested to pay the return transportation. No authorization will be given to broadcast individual records from the series.

The Bureau has available enough transcriptions to put on a 15-minute program once a week for four years. For information address the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago.

Among county societies which used the transcriptions in 1947 were those in the following counties: Ashland, Butler, Clark, Jefferson, Miami, Montgomery, Richland, Sandusky, Seneca, Summit, and Trumbull; also Hamilton and Marion County Woman's Auxiliaries.

Societies in the following counties used the series in 1948: Ashland, Montgomery, Summit, Butler (Auxiliary), and Lucas.

A summary of the occupational disease claims filed with the Industrial Commission of Ohio, as reported in *The Monitor*, during the year 1947 shows a slight increase over the previous year. Since 1944, when the maximum number of occupational disease claims filed reached the high point of 7,949, there was a gradual diminution, especially in claims resulting from dermatitis.

Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

At the April 21 meeting of the Adams County Medical Society in West Union, Dr. William T. Foley, Cincinnati, spoke on "Conditions of the Cervix."

BUTLER

At the Scientific Meeting on April 28, the Butler County Medical Society had as principal speaker Dr. Lloyd E. Larrick, Cincinnati, who spoke on "Anesthesia Techniques as an Aid to Diagnosis." The Second Annual Invitational Meeting was held on May 13 at the Manchester Hotel, Middletown.

CLINTON

Dr. Elmer R. Arn, of Dayton, spoke on "Management of Thyroid Diseases" at the April meeting of the Clinton County Medical Society in Wilmington.

HAMILTON

Guest speaker at the April 20 meeting of the Academy of Medicine of Cincinnati was Dr. Helen Vincent McLean, associate of the Institute for Psychoanalysis, Chicago, who spoke on "Treatment of the Neuroses."

HIGHLAND

Dr. Charles E. Holzer, Jr., Gallipolis, addressed the April meeting of the Highland County Medical Society on the subject, "Early Ambulations."

WARREN

Dr. Nelson Cragg, of Cincinnati, discussed diseases of the nose and throat at the April meeting of the Warren County Medical Society in Lebanon.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

"Preoperative and Postoperative Care" was discussed by Dr. J. H. Pratt of Rochester, Minn., guest speaker at the April 19 meeting of the Clark County Medical Society. The final scientific meeting of the Society for the season was held on May 17 at the Nurses' Residence, Springfield City Hospital. Guest speaker was Dr. Leon Schiff of Cincinnati, who spoke on "Gastrointestinal Bleeding."

DARKE

Dr. Walter K. Gregg of Dayton spoke on "Toxemias of Pregnancy" at the April 20 meeting of the Darke County Medical Society in Greenville.

MIAMI

Principal speaker at the April meeting of the Miami County Medical Society in Piqua was Dr. Louis G. Herrmann, of the University of Cincinnati College of Medicine. On May 6 a special "Ladies Night" meeting was held at the Troy Country Club. Guest speaker was Mr. Mack Sauer, editor of the *Leesburg Citizen*.

MONTGOMERY

The tenth anniversary of the Dayton Obstetrical and Gynecological Section of the Montgomery County Medical Society was held at the Van Cleve Hotel April 21. The nine past-presidents were accorded special honors. Dr. Allan C. Barnes, Ohio State University College of Medicine, was guest speaker.

At the General Practitioners Section, Dr. Lynne E. Baker discussed "Newer Concepts of Pulmonary Tuberculosis and Chest Diseases."

At the Scientific Section of the Society early in April, Dr. Bruce K. Wiseman, Ohio State University College of Medicine, spoke on the modern treatment of anemia.

Guest speaker at the May 5 meeting of the Society was Dr. Robert Elman, Washington University School of Medicine, St. Louis, Mo., who spoke on "Parenteral Feeding."

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D.,
UPPER SANDUSKY)

LOGAN

Members of the Logan County Medical Society, at their April meeting in Bellefontaine, heard a discussion on cancer by Dr. Roswell S. Fidler of Columbus.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

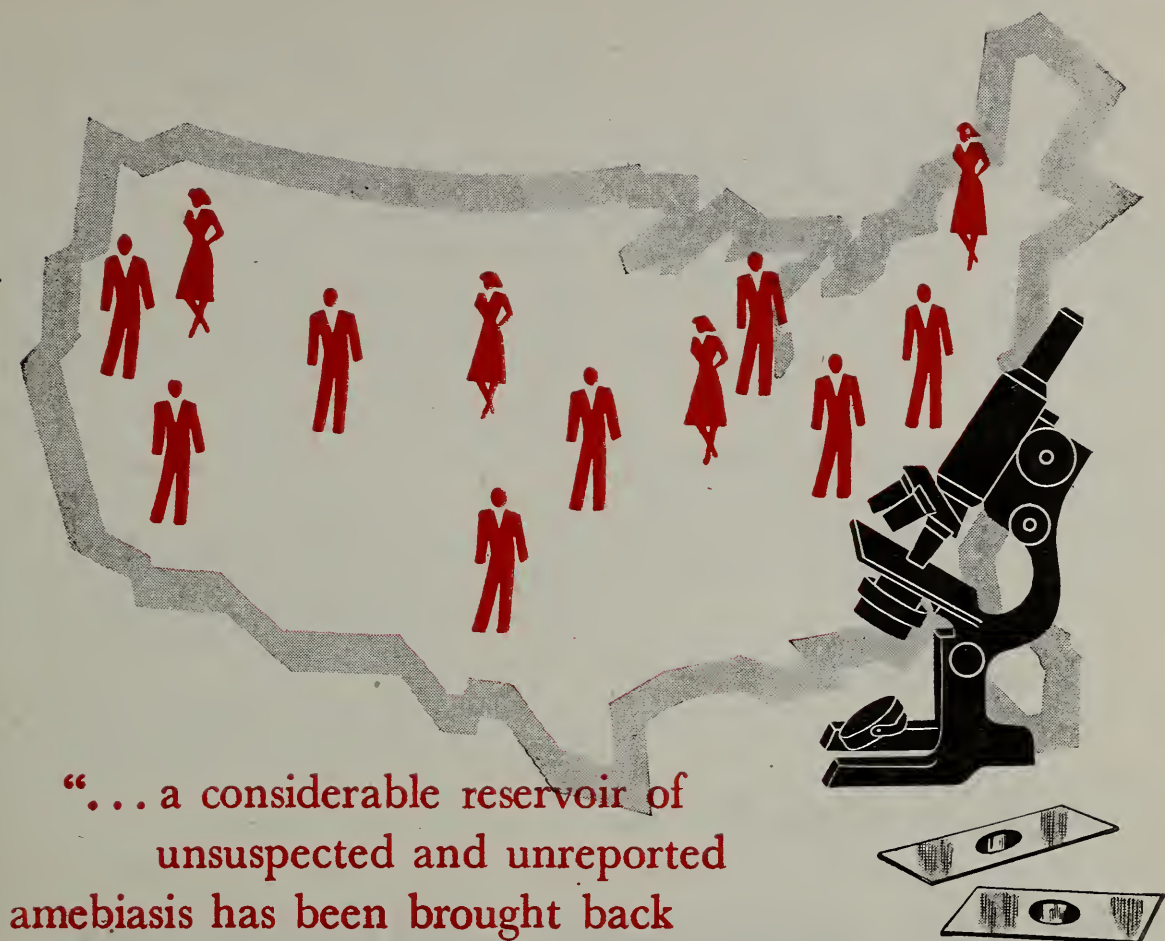
LUCAS

The program of the Academy of Medicine of Toledo and Lucas County for May was as follows:

May 7—General Meeting, "The Clinical Aspects of Hypersplenism," by Dr. Bruce K. Wiseman, Ohio State University College of Medicine, Columbus, and "The Pathology of Hypersplenism," by Dr. Emmerich von Haam, also of the O.S.U. medical faculty.

May 14—Section on Pathology, Experimental Medicine and Bacteriology, "Physiological Rationale of Medical and Surgical Therapy for Peptic Ulcer," by Dr. M. I. Grossman, University of Illinois.

May 21—Medical Section, "Sludged Blood,"



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1. Editorial: *The Problem of Amebiasis*, J.A.M.A. 134:1095 (July 26) 1947.
2. Wilbur, D. L., and Camp, J. D.: *Amebic Disease of the Cecum: Clinical and Radiological Aspects*, *Gastroenterology* 7:535 (Nov.) 1946.
3. Morton, T. C. St. C.: *Diodoquin for Chronic Amoebic Dysentery in Service Personnel Invalided from India*, *Brit. M.J.* 1:831 (June 16) 1945.

by Dr. Melvin H. Knisely, University of Chicago.

May 28—Surgical Section, "The Role of the Intervertebral Disk in Back Pain," by Dr. Frederick B. Hawkins, Toledo.

PUTNAM

Dr. Edward B. Pedlow of Lima, addressed the Putnam County Medical Society meeting in April on the subject, "Abdominal Pains." At the May 4 meeting, Dr. Frederic G. Maurer of Lima spoke on "Cardiac Arrhythmias."

WOOD

The April Scientific Session of the Wood County Medical Society was conducted by Dr. William A. Neill, of Toledo. Working with him were Dr. M. G. Means and Dr. A. E. Rhoden. Dr. Neill followed the pattern of a clinical and pathological conference, describing a patient suffering from an acute abdominal condition, while Dr. Means presented a series of X-ray films of the patient and Dr. Rhoden gave laboratory findings.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

The Annual Meeting of the Academy of Medicine of Cleveland was held on May 21 at the

Medical Library Auditorium, followed by a social hour directed by the Woman's Auxiliary. Guest speaker was Dr. Francis D. Moore, Harvard Medical School. His subject was "Some Current Researches on Metabolism in Surgical Patients."

On May 14, the Experimental Medicine Section and the Cleveland Section of the Society for Experimental Biology and Medicine held the following program: "An in Vivo Determination of the Distensibility of the Venous System of the Hind Leg," by R. S. Alexander, Ph.D., department of physiology, Western Reserve University; "The Effects of Temporary Complete Renal Ischemia in Rats," by Dr. Simon Koletsky and Betty Pintar of the department of pathology, W. R. U.; "The Reaction of Alloxan With Glutathione and Cysteine," by J. W. Patterson, Ph.D., Dr. Arnold Lazarow and Stanley Levey, Ph.D., of the department of anatomy, W. R. U.; and "Partial Protection Against Alloxan Diabetes with Nicotinamide," by Dr. Lazarow.

LAKE

Dr. H. Z. Lund and Dr. W. C. McCally of Western Reserve University School of Medicine discussed cancer of the large intestine and other diseases of the colon at the April meeting of the Lake County Medical Society.

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Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

Dr. George M. Wilcoxon of Alliance presented a paper on "The Early Diagnosis of Carcinoma of the Cervix" at the April meeting of the Columbiana County Medical Society.

PORTAGE

Dr. Normand L. Hoerr, Western Reserve University School of Medicine, was guest speaker at the May 6 meeting of the Portage County Medical Society in Ravenna. His subject was "Recent Studies on the Autonomic Nervous System." At its April meeting the Society voted to purchase for distribution to its members physicians' automobile emblems bearing the words "Portage County."

TRUMBULL

At the April meeting of the Trumbull County Medical Society, Dr. A. E. Rakoff, Jefferson Medical College, of Philadelphia, spoke on "Endocrine Therapy in Menstrual Disorders."

Seventh District

(COUNCILOR: R. J. FOSTER, M.D., NEW PHILADELPHIA)

BELMONT

Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association, addressed the April meeting of the Belmont County Medical Society on the subject, "Choice of Analgesia and Anaesthesia in Obstetrics."

Principal speakers at the May 13 meeting of the Belmont County Medical Society included Dr. David G. Gillespie, Dr. Ruel J. Foster and Dr. Alfred E. Winston.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

MUSKINGUM

Dr. David A. Boyd, professor of psychiatry at Indiana University School of Medicine, addressed the April meeting of the Muskingum Academy of Medicine on the subject, "Psychosomatic Medicine."

Ninth District

(COUNCILOR: J. PAUL McAFEE, M.D., PORTSMOUTH)

SCIOTO

A color film entitled "American Medical Association Physical Diagnosis Clinic" was shown at the April meeting of the Hempstead Academy of Medicine in Portsmouth. Dr. Clyde M. Fitch was chairman of the program. Dr. Owsley Grant, of Louisville, Ky., was guest speaker at the May 10 meeting of the Academy. His sub-

For simple diagnosis of...

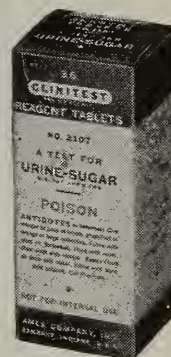
URINE-SUGAR

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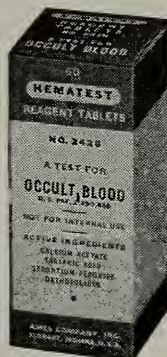
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ject was "Modern Urology, Its Relation to Medicine and Surgery."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)
FRANKLIN

During May two symposia were held by the Columbus Academy of Medicine in the Columbus Gallery of Fine Arts. On May 3, a symposium was conducted by the staff of University Hospital with Dr. Bruce K. Wiseman presiding. On May 17 the staff of St. Francis Hospital conducted a symposium with Dr. Tom F. Lewis in charge.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)
LORAIN

"Early Diagnosis of Cancer" was the subject of an address by Dr. J. Robert Andrews, Cleveland, at the April meeting of the Lorain County Medical Society. "Essential Laboratory Procedures for the General Practitioner" was the topic of a talk by Dr. Edward A. Marshall at the May 11 meeting.

WAYNE

At the April meeting of the Wayne County Medical Society, Dr. Maurice Newberger, executive director of the Bureau of Juvenile Research, Columbus, explained the functions and procedures of the Bureau.

Woman's Auxiliary News

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

25th Annual Meeting

Program of the 25th Annual Meeting of the Woman's Auxiliary to the American Medical Association, June 21 to 25, Chicago, is given below. Auxiliary headquarters will be on the mezzanine floor of the Hotel LaSalle. Members are requested to register early and obtain badges and programs of the social functions.

SUNDAY, JUNE, 20, 1948

2:00 P. M. to 4:00 P. M. Registration (Mezzanine floor)

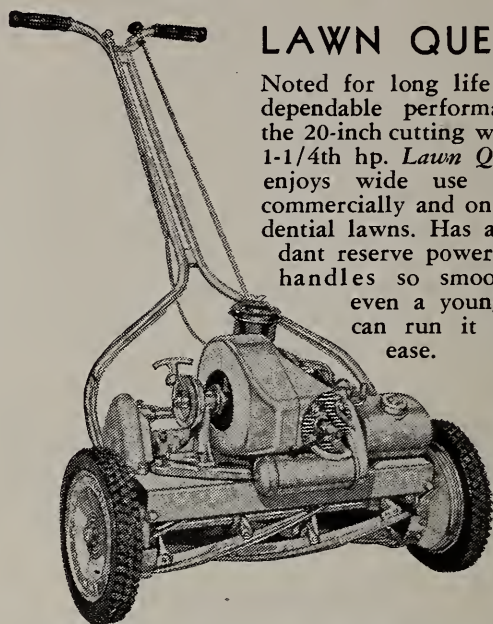
MONDAY, JUNE 21

4:00 P. M. Tea in honor of Mrs. Eustace A. Allen, President, and Mrs. Luther H. Kice, President-Elect, in the Century Room. All doctors' wives are cordially invited.

TUESDAY, JUNE 22

9:00 A. M. Formal opening of the 25th Annual Meeting of the Woman's Auxiliary to the American Medical As-

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sociation, Illinois Room (Mezzanine floor), Mrs. Allen presiding.

12:00 P. M. Luncheon in honor of the Past-Presidents of the Woman's Auxiliary to the American Medical Association, Grand Ballroom (19th floor). Guest speaker: Dr. Morris Fishbein, editor, *Journal of the American Medical Association* and *Hygeia*.

2:00 P. M. Afternoon Session—reports of Chairmen of Standing Committees, reports of Nominating Committee (first reading).

8:00 P. M. Opening meeting of the American Medical Association, Grand Ballroom, Hotel Stevens, Members of the Woman's Auxiliary and guests are welcomed.

WEDNESDAY, JUNE 23

9:00 A. M. General Session of the Woman's Auxiliary to the A. M. A., Illinois Room (Mezzanine floor). Reports of State Presidents.

12:30 P. M. Annual luncheon in honor of Mrs. Allen, President, and Mrs. Kice, President-Elect. Grand Ballroom.

2:00 P. M. Report of Nominating Committee. Election and Installation of Officers.

THURSDAY, JUNE 24

6:30 P. M. Annual dinner of the Woman's Auxiliary for members, husbands, and guests, Grand Ballroom.

9:00 P. M. Reception and Ball in honor of the President of the American Medical Association—Palmer House.

* * *

ALLEN

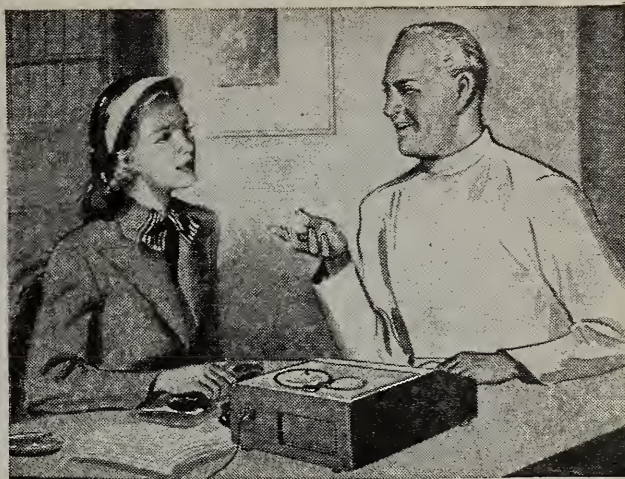
The following officers were elected at the last meeting of the Woman's Auxiliary to the Academy of Medicine of Lima and Allen County: Mrs. Virgil Hay, president; Mrs. R. L. Lecklenberg, president-elect; Mrs. I. D. Baxter, secretary; and Mrs. W. B. Ludwig, treasurer. The members voted to make the loan scholarship for a student in nurses training a continuing project and will inaugurate a scholarship in the Fall to both St. Rita's Hospital and Memorial Hospital. Proceeds from the recent benefit card party given by the auxiliary will open the fund.

CUYAHOGA

Members of the Woman's Auxiliary to the Academy of Medicine of Cleveland served as hostesses and took reservations when the Academy of Medicine gave a benefit dinner-dance on April 10 in the Rainbow Room, Hotel Carter, Cleveland.

FAIRFIELD

Members of the Woman's Auxiliary to the Fairfield County Medical Society met at the home of Mrs. J. J. Hoodlett, Lancaster, on



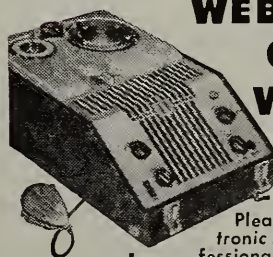
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April 12. Program highlights were reports of the recent State Convention in Cincinnati given by Mrs. William Monger and Mrs. C. P. Swett, Director of the Eighth District. Mrs. C. C. Watts, guest speaker for the evening, spoke on "Women in Medicine."

FRANKLIN

Mrs. Thomas Herbert opened the Governor's Mansion to the Woman's Auxiliary to the Columbus Academy of Medicine for its meeting on Monday, May 3. Hostesses from the auxiliary to assist in entertaining were: Mrs. Harry LeFever, Mrs. Paul R. Bauman, and Mrs. L. W. Rohr. Miss Martha Jackson, Chairman of Occupational Therapy of Ohio State University, discussed her work in that field of service. A movie was shown of work done by recreational therapists in Columbus clinics that have been assisted in their work by the auxiliary.

HARDIN

The Woman's Auxiliary to the Hardin County Medical Society met for the regular monthly meeting Thursday, April 15, in the club rooms of Hardin County Veterans' Memorial Park, with 16 members in attendance. Mrs. A. W. Sage was chosen president-elect and Mrs. H. R. Johnson, secretary. A report of the state convention held in Cincinnati was given by the president, Mrs. S. P. Churchill.

HIGHLAND

The Woman's Auxiliary to the Highland County Medical Society met for luncheon on May 5. In answer to roll call each member responded with "New Developments in Medicine" which proved very interesting and instructive. The report of the state convention was given.

LICKING

Tuesday night members of the Auxiliary to the Licking County Medical Society assembled for dinner in Hull Place and a short business meeting followed. Mrs. G. A. Gressle who represented the auxiliary at the State convention in Cincinnati gave her report. Later bridge was played.

LUCAS

"Recent Progress in Music Therapy" was the topic of a talk given by Dr. Ira M. Altshuler, director of the Group and Music Therapy Department at Wayne County General Hospital, Eloise, Michigan, in the Woman's Club under the auspices of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County. A luncheon was served for members of the auxiliary only. Two hundred members of the auxiliary together with members of ten invited groups attended the lecture.

PICKAWAY

Seventeen senior high school girls interested in the profession of nursing were guests at the

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tea at the home of Mrs. Lloyd Jonnes and sponsored by the Woman's Auxiliary to the Pickaway County Medical Society. Miss Margaret Hunsicker, assistant general secretary of the Ohio State Nurses Association, spoke on "Nursing" and listed the various programs including the three-, four-, and five-year courses. Other guests for the afternoon were Mrs. George Cooperrider, Columbus, editor of *Medical Auxiliary News*, and Mrs. N. F. Reiff, Washington C. H., director of the Eleventh District.

RICHLAND

Twenty-five senior girls from all Richland County high schools who are interested in the nursing profession were honored at a tea given at the Mansfield General Hospital Nurses' Home. Hostesses were members of the Woman's Auxiliary to the Richland County Medical Society. Receiving the one hundred in attendance was Miss Carrie Beal, supervisor of nurses.

TRUMBULL

The regular monthly meeting of the Woman's Auxiliary to the Trumbull County Medical Society was held April 16, at the Children's Home in Warren. Reports of the State convention held in Cincinnati were given.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society was entertained April 9 in the home of Mrs. Henry Engel. Reports were given by Mrs. William Hudson, a delegate to the State convention in Cincinnati. Tuscarawas County has three of the 28 Ohio delegates to the National Convention in Chicago. A bake sale was held on April 24, proceeds of which are to be used to endow a room at Union Hospital.

Dr. Blain Heads Psychiatric Group

Dr. Daniel Blain, formerly chief of Neuropsychiatric Services for the Veterans Administration, has accepted the newly established position of medical director of the American Psychiatric Association. The executive office of the Association is at Room 924, Rockefeller Plaza, New York City 20, where he may be addressed.

Rabies Inoculation Upheld

Cincinnati's rabies vaccination ordinance for dogs was upheld when early in May, Judge Thomas H. Morrow refused to grant a temporary injunction halting enforcement. Suit was brought by a citizen who claimed her dog became rabid as a result of the inoculation. Dr. Carl A. Wilzbach, health commissioner, testified that it is impossible for the type of vaccine used to cause rabies.

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ROUNDUP ON PREPAID MEDICAL CARE PLANS

At a recent meeting of the Blue Shield board of trustees in Iowa, it was decided that a reduction in subscriber rates was entirely possible in view of two years' favorable experience. The reduced rates represent a monthly saving to subscribers of twenty-five cents for individuals and fifty cents for families.

* * * *

At the last meeting of the Blue Shield Commission four new members were admitted to the association and one member transferred from an associate to full member status. There are now fifty-two Blue Shield member plans in Associated Medical Care Plans, the national association of Blue Shield plans. Added to full membership were Medical Service, Inc., Ashland, Ky.; Surgical Service, Inc., Bluefield, W. Va.; Chicago Medical Service, Chicago; and Mutual Medical Insurance, Inc., Indianapolis. Transferred from associate to full membership was Minnesota Medical Service.

* * * *

Two vacancies on the Blue Shield Commission were filled at the Commission's last meeting in Los Angeles with the election of Dr. Elmer Hess, Erie, Pa., and Dr. Walter Martin of Norfolk, Va. The new members of the Blue Shield Commission were nominated by the A.M.A. Council on Medical Service to fill vacancies created by the resignation of two Commissioners who had previously represented that body.

* * * *

Enrollment studies for the first quarter of 1948, nearly completed on May 1, indicate that total membership in non-profit prepayment plans is close to the 8,000,000 mark. Total enrollment on December 31, 1947, was tabulated at 7,328,143, representing a gain during 1947 of approximately 60 per cent over the previous year's total, 1947 having witnessed the largest gain in the history of non-profit plans.

Activities of The Editor

On Monday evening, April 26, Dr. Jonathan Forman, Editor of *The Journal*, was the guest speaker at the Delaware (Ohio) Rotary Club's Annual Town and Country Dinner. His subject was "A Complete Soil and Water Conservation Program Can Bring You Better Health and More Prosperity Than Any Socialization Proposal."

At the tenth annual meeting of the Ohio State Archaeological and Historical Society, Dr. Forman, permanent Chairman of the Committee on Medical History and Archives, gave the Chairman's address, "The Social, Economic, and Professional Background of the Era of Industrial Capitalism Just Ended in the United States." He also read a paper, "The Columbus Medical Journal."

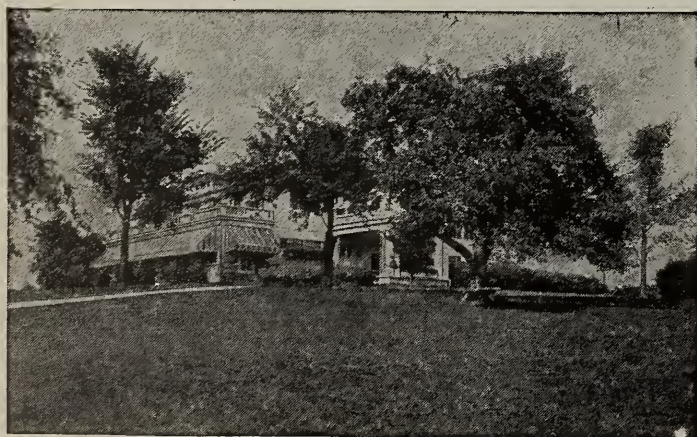
"Nutrition and Man's Relation to the Soil," a five-page article written by Dr. Forman, appeared in the 22nd annual Flower Show Directory of the Garden Club of Illinois, Inc.

On April 13, Dr. Forman addressed the Management Group of the Mansfield Westinghouse Plant at the last of a series of five seminars for 1947-1948 on "Survey, Analyze, and Correct Your Own Health and That of Your Fellow Workmen."

On April 14, Dr. Forman spoke to the women of the Riverside Methodist and the Bethel Church on "What Rural Living Can Mean To You and Yours in the Way of Health and Happiness."

An article by Dr. Forman titled "Human Development Depends on the Soil," appeared in March, 1948, issue of *The Contour*.

Dr. Forman has just published a "Directory of Physicians Throughout the World Interested in Allergy." The book contains nearly 2,000 names.



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Rulings of Attorney General

A county, as a political sub-division of the State, is responsible for the hospital care of transient indigents who do not have legal settlement in Ohio, Attorney General Hugh S. Jenkins recently ruled. The Attorney General pointed out that the county commissioners must pay this poor relief cost rather than the local county relief authorities.

* * *

The syllabus of Opinion No. 2704, issued recently is as follows:

1. The payment required to be made by the state to trustees of a county tuberculosis hospital as provided in Section 3139-23, General Code, is to be retained by said trustees and used by them in the operation, maintenance, and improvement of the service of such tuberculosis hospital, and no portion thereof is to be paid to the board of county commissioners for improvements to the buildings of such hospital.

2. Under provisions of Section 3139-13, General Code, all taxes collected pursuant to the levy made by the county commissioners for the purpose of providing funds and for the management and control of a county tuberculosis hospital are to be paid over to the trustees of such hospital and deposited and expended by them in the manner provided as to taxes collected for and paid over to the trustees of a district tuberculosis hospital under the provisions of Sections 3139-6, General Code.

* * *

State tuberculosis care funds cannot be used to pay the cost of treating a patient sent to a hospital outside the state, according to a ruling issued in December. In an opinion to State Auditor Joseph T. Ferguson, he pointed out that the funds are designed to "aid and subsidize only Ohio hospitals".

March of Time Medical Film Available for Lecturers

The Committee on Medical Motion Pictures of the American Medical Association recently purchased several copies of the March of Time film entitled "New Frontiers of Medicine," 16 mm., black and white, sound, 600 feet, showing time 17 minutes.

It is a revision of the film entitled "Your Doctors—1947" which has been shown in many public theaters throughout the country. The new picture consists of brief sequences illustrating various phases of medical progress. Physicians who are called upon to address lay audiences such as service organizations, Parent-Teacher Associations, and other groups, may obtain the film from the committee.

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Surgical Anatomy & Clinical Surgery, two weeks, starting July 6, Aug. 16, Sept. 27.

Surgery of Colon & Rectum, one week, starting June 14, Sept. 20. Surgical Pathology every 2 weeks.

UROLOGY—Intensive Course, two weeks, starting Sept. 27.

FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting June 7, October 25.

OPHTHALMOLOGY—Intensive Course, two weeks, starting Sept. 20.

Refraction Methods, four weeks, starting Oct. 11. Ocular, Fundus Diseases, one week, starting June 7, Nov. 15.

GYNECOLOGY—Intensive Course, two weeks, starting Sept. 13. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 27.

OBSTETRICS—Intensive Course, two weeks, starting June 21, Sept. 27.

MEDICINE—Intensive Course, two weeks, starting Oct. 11. Personal Course in Gastroscopy, two weeks, starting June 28, July 12.

Electrocardiography & Heart Disease, two weeks, starting August 2.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 4. Clinical Course every two weeks.

OTOLARYNGOLOGY—Intensive Course, two weeks, starting October 18.

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Postgraduate Courses

The University of Pittsburgh School of Medicine has announced a postgraduate orientation course in allergy under the direction of Dr. Leo H. Crip. This course is to continue over a series of 10 Thursday afternoons, beginning with September 2, 1948. It will include didactic, laboratory and clinical presentations in allergy and the related specialities—dermatology, pediatrics, rhinology, etc. Inquiries may be addressed to Dr. Samuel P. Harbison, chairman, Committee on Post Graduate Education, School of Medicine, O'Hara St., Pittsburgh, Pa.

* * *

A postgraduate course in the "Modern Treatment of Fractures and Other Traumatic Conditions," will be held at the Massachusetts General Hospital, September 20-29, under auspices of the Harvard Medical School. Information may be obtained by writing, Assistant Dean, Courses for Graduates, Harvard Medical School, 25 Shattuck St., Boston, Mass. The course is covered by the G. I. Bill of Rights.

* * *

The Chicago Medical Society is offering two postgraduate courses in September. A course in hematology and neurology will be given Sept. 13-18; and another in cardiovascular and respiratory diseases will be given Sept. 20-25, on Northwestern University Medical School campus. Information may be secured by writing the Chairman, Committee on Postgraduate Medical Education, Chicago Medical Society, 30 North Michigan Avenue, Chicago 2, Illinois.

Health Transcriptions Offered

Now available from the Bureau of Health Education of the American Medical Association is a new series of electrical transcriptions entitled "Music With Your Meals". The series consists of 13 quarter-hour interview-type programs. Scripts, posters, and press releases accompany the recordings. Local use is conditioned on approval by the county medical society. Transcriptions are available in complete series only, on loan free of all charge except return transportation. Local groups are expected to take appropriate responsibility for successful broadcasting and for return of platters.

Infant Mortality Rate Is Down

The infant mortality rate in the United States in 1946 was 33.8 deaths under 1 year per 1,000 live births, or 11.7 per cent less than the rate of 38.3 in 1945, according to figures of the National Office of Vital Statistics.

The number of infant deaths which occurred during 1946 was 111,063, or 6,379 more than during 1945. This rise reflects the tremendous increase in the number of births during 1946. The relative frequency of infant death, as measured by the infant mortality rate, decreased.

The five leading causes of death during infancy, and the infant mortality rate in 1946, were: Premature birth, 12.1 per thousand; congenital malformations, 4.5; pneumonia and influenza, 3.8; injury at birth, 3.6; diarrhea, enteritis, and ulceration of the intestines, 1.7.

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The Physician's Bookshelf

By Jonathan Forman, M.D.

Nicolaus Pol Doctor, 1494, by Max H. Foster, issued in celebration of the Fiftieth Anniversary of The Cleveland Medical Library Association, (\$7.50. *Herbert Rerchner, 34 East 62nd Street, New York City*) contains a critical text on his guaiac tract (on the use in the treatment of syphilis), edited and translated by Dorothy M. Schullian. There rests in the Cleveland Medical Library a great collection of books from the library of this physician. The rest, with the exception of 30 volumes of the Pol books, are in the Candido and the Yale Collections. All are carefully recorded and described here by a former chief of the History of Medicine, Division of the Army Medical Library, now professor of philosophy at the University of Illinois.

Corn Country, by Homer Croy, (*Duell, Sloan, and Pearce, New York City*) is a book about folkways. The author has mixed his facts with jokes and made learning the history of the country a pleasure. The book in fact is a chronicle that goes back to the countyseat wars, the grasshopper plagues, and the plow that broke the plains. The whole story is brought up to date with talks about a farmers' radio station, Henry Wallace's research in hybrid corn, and an account of what John L. Lewis' home-town folks think of him. It turns out to be a fascinating story of the Corn Country.

The Epithelia of Woman's Reproductive Organs, by George N. Papanicolaou, M.D., Herbert F. Traut, M.D., and Andrew A. Marchetti, M.D., (\$10.00. *The Commonwealth Fund, New York City*) is a series of some 24 beautiful plates in color and some 50 pages of text. It nevertheless is the complete story of our knowledge of the anatomy of the estrous cycle for it is the work of the outstanding cytologist who has devoted the last thirty years to the subject. Associated with him has been Dr. Traut whose experience in gynecological pathology serves well to supplement the knowledge of the senior author; and for the last six years, Dr. Marchetti has been an active participant in this study as another active teacher of gynecology.

Nutrition and Hormones, by Leo T. Samuels, Ph.D., (\$1.65. *C. C. Thomas, Publishers, Springfield, Illinois*) is one of the American Lecture Series in Endocrinology edited by Willard O. Thompson of the University of Illinois.

One cannot help but praise both the editor and the publisher in having the courage to bring out this beautiful little booklet of 50 pages. I have always insisted that what the reading por-

tion of our profession needs more than anything else are short booklets which would bring the reader up to date in some special field of his interest. This is not a profitable phase of publishing because no method of distribution has yet been worked out that works satisfactorily. This series suggests that perhaps subscriptions to a series could well be sold to those who have these special interests.

The author's viewpoint appeals very strongly to me. He says: "The endocrine glands are specific chemical factories upon which the whole organism depends. But, like all factories, their ability to produce useful products depends upon the raw materials they receive." Therefore, the fundamental phase of all endocrine problems is that of nutrition. So all problems of the endocrine are considered in this lecture from the viewpoint of the glands' nutrition which involves the quality of the food obtainable, the degree of hunger experienced, and the question of food acceptance.

American Medical Research, by Richard H. Shryock, (\$2.50. *The Commonwealth Fund, New York City*) is another story by the New York Academy of Medicine Committee on Medicine and the Changing Order. This one is by the well-known medical historian.

The modern use of the word "research" makes it almost as meaningless as "education." Both are, however, passwords to the purse of the American people. Consequently before we go off the deep end with legislative appropriations for research, we should examine what investigative work has served the people and what has just been the plaything of its owners. Several of the medical historians have suggested that the term "research" be limited to those investigations which involve new relationships and therefore imagination or other mental processes, besides observation.

Europe's Population in the Interwar Years, by Dudley Kirk, (\$4.00. *Columbia University Press, New York City*) presents an inventory of the continent's human resources. Through most of its earlier history the population of Europe had a Mediterranean orientation but with the rise of industrialization it has moved to an Atlantic orientation. The Population of Europe in 1940 was 350 million more than in 1800. Since 1900 alone there has been an increase of 140 million, besides the millions that have been sent overseas. Such increases cannot continue indefinitely.

The essence of the vital revolution now going

on in Europe is the transition from wasteful mortality and reckless procreation to a new balance of low death rates and lessened fertility. The reduction in death rate is more closely associated with a larger supply of consumer goods than with advances in medical techniques—better diets, better clothing, better housing.

It seems to me that the author places undue emphasis upon individual practice of birth control in society so abnormal through its increased urbanization as to be of itself a controlling factor in fecundity.

The author also feels no regrets in the passing of the mantle of political leadership from the handful of Western European powers since the highest standards of welfare have been set by those small nations who have not devoted their efforts to national aggrandizement. Furthermore, the loss of political power might just possibly increase the cultural leadership that Western Europe has long exercised.

Physiology of Man in the Desert, by E. F. Adolph and Associates in Physiology at the University of Rochester, (\$6.50. *Interscience Publishers, Inc., New York City*) contains work done under a contract with the United States Office of Scientific Research and Development. These data do have many peace time applications. The basic principle brought out is that heat exchanges are greatly exaggerated in a hot environment. The human body takes care of this exchange by using water for evaporative cooling. Man's chief concern in the desert is to have available as much water as he needs to replace all that he evaporates as sweat.

New Hope for Sufferers from Arthritis, by Max Warmbrand, Ph. T. (\$2.50. *Knickerbocker Publishing Company, New York City*) presents a system of therapy based upon the vitality of the individual as a whole and relying upon a simple complete diet, sunshine, fresh air, and exercise.

Health Facts for College Students, by Maude Lee Etheredge, M. D., (\$2.50. *W. B. Saunders Company, Philadelphia*) is a textbook on individual and community health by the physician-instructor at Mary Baldwin College. It covers physiology and hygiene, and gives good advice for the use of our bodies and our minds.

The Rights of Infants, by Margaret A. Ribble, M. D., (\$2.00. *Columbia University Press, Morningside Heights, New York*) discusses their early psychological needs and the way these can be satisfied. The natural impulses of an infant cannot be safely arbitrarily damned up or sniffed out when their expression becomes inconvenient for adults. Parents must never forget that healthy emotions as well as a free creative intelligence are rooted in early infant experiences.

Education and Health of the Partially Seeing Child, by Winifred Hathaway, (\$2.50. *The National Society for the Prevention of Blindness, Columbia University Press Morningside Heights, New York*) is intended for the use of administrators, supervisors, teachers, nurses, social workers, and all concerned with the welfare of children.

The Prevention of Blindness of the Ohio Commission for the Blind, working in cooperation with the State Department of Special Education is responsible for holding diagnostic eye clinics for the purpose of locating these pupils. These clinics are preceded by demonstration of vision testing for teachers in the district in which the clinics are to be held. The teacher then in each school district completes eye testing upon her pupils and will pick out with the help of the commission, those who are to be studied at the diagnostic clinic. The commission sees to it that the children who need it after refraction, medical care, or surgical treatment have been given get the special type of education needs through the State Department of Special Education.

Health—Mental, Moral, and Physical, by Horace W. Soper, M. D., (\$2.00. *The Christopher Publishing House, Boston, Massachusetts*) is a book on hygiene by this distinguished gastroenterologist. He advocates stretching and sunning, much sleep, the use of tobacco and alcohol in moderation. He condemns milk as a source of infection and the cause of dental decay, and also condemns public feeding of those on relief.

British Surgical Practice under the general editorship of Sir Ernest Rock Carling and J. Paterson Ross in eight volumes (Volume I. \$15.00. *C. V. Mosby, St. Louis, Missouri*) is a practical work for practical men intended for many surgeons who do not have easy access to libraries and teaching centers. This volume deals with fundamentals such as pain, acidosis, appetite, after case, anesthesia.

It is all on the same high level as the chapter on Allergy by the late George Bray who tells the general surgeons and specialists all they need to know in four pages.

The Golden Isle, by Frank B. Slaughter, (\$3.00. *Doubleday & Company, Garden City, New York*) is an interesting novel based on the fictionization of history of Spanish Florida in the year 1817. You will enjoy it.

Land, Men, and Credit, by Leo Manion, (\$2.00, cloth. \$1.00, paper. *Island Press, 420 West 24th Street, New York City*) gives the facts about sources and types of credit. An ingenious chart is included which helps very much to determine what one can afford to pay for a farm. The

author has more than 30 years' experience in agricultural credit and so this small book of 61 pages can be depended upon to give you much information that you need to have if you are planning on buying a farm.

Operative Gynecology, by H. S. and R. J. Crossen, M. D., (\$15.00. Sixth Edition. *C. V. Mosby Company, St. Louis, Missouri*) contains much new material. Of this, the most important is a detailed consideration of the workable services to prevent cancer of the ovaries, the uterus, and the external genitalia. Another important advance is described in measures for giving more effective local relief to patients with general handicaps which contraindicate operative removal of the seriously troublesome pelvic lesions. So this standard text will continue to hold its place of leadership as it has for the past 30 years.

Tuberculosis, by F. M. Pottenger, Sr., M. D., (\$12.00. *C. V. Mosby Company, St. Louis, Missouri*) presents a discussion of the Phthisiogenesis, Immunology, Pathologic Physiology, Diagnosis and Treatment of the Disease. The author approaches his task with the idea that we now have arrived at the place where every one of our theories must be subjected to careful scrutiny. Among other things he looks upon the disease as only mildly injective thus affording the greatest possible opportunity of eradication. He holds that the primary infection creates protection. He seems to be saying in his own way what many of us have been emphasizing of late, i.e., that there is an absolute or primary cause of the disease residing in the host and not in most instances in the germ that makes the patient succumbed to the infection.

Nutrition in Relation to Cancer, A Symposium of the New York Academy of Science, (\$2.00. *The New York Academy of Sciences, Central Park West at 79th Street, New York*) reviews the facts now firmly established which provide powerful tools with which to work:

(1) A variety of definite, pure compounds are known that apparently initiate the development of cancers so that one can lay out a research program on a molecular basis. (2) Under controlled conditions with animals, several substances that are characteristic of natural diets can completely decide the issue of whether or not tumors will develop.

Brief Psychotherapy, by Bertrand S. Frohman, M. D., (\$4.00. *Lea & Febiger, Philadelphia, Pennsylvania*) is another book in step with the times emphasizing the problem of neurosis from the viewpoints of patient, physician, and psychotherapist. Each of us is, as W. C. Alvarez says in his foreword, "distressed many times a month as we see the unfortunate results of

what some well-trained brother physician doubtless thought was the best possible type of modern scientific medicine . . . Today it pays a physician much better financially and gives him much more weight with patients to practice what looks like the best possible medicine but what is actually a bad form of decerebrate medicine."

Treatment in General Practice, by Harry Beckman, M. D., (\$11.50. Sixth Edition, *W. B. Saunders, Philadelphia, Pennsylvania*) keeps pace with the times by introducing for the first time some 20 diseases and making extensive revisions on many others. Since most of us received little or no valuable instruction in therapeutics in our student days, Beckman's book has been a mainstay in our reference library.

Ashes and Fire, by Jacob Pat, (\$3.25. *International Universities Press, New York City*) is a narrative of the plight of the poor Polish Jew in Poland as told by a reporter freshly arrived from a 60-day inspection tour. All who believe that man is a follower and true believer of the great religions should read this indictment.

Laboratory Technique in Biology and Medicine, by E. V. Cowdry, (\$4.00. *Williams & Wilkins Company, Baltimore, Maryland*) was known on its first appearance as **Microscopic Technique in Biology and Medicine**. It gives techniques from staining the A-V bundle to Zymonema Dermatitis.

1947 Year Book of Dermatology and Syphilology, (\$3.50 *The Year Book Publishers, Chicago, Illinois*) is the annual survey by Marion Sulzberger, M.D., and Rudolf Baer, M.D., that allergists, dermatologists, and many men in general practice look forward to at the beginning of each new year. Every physician should read the leading article. This is always true of each annual but this year it is doubly true in that it deals with "Some Common Misconceptions Regarding Dermatology."

Medical Aspects of Growing Old, by A. T. Todd, M.B., (\$3.50. *A William Wood Book, Williams & Wilkins Company, Baltimore, Maryland*) is based upon the need for a sound nutrition which the author believes is somewhat different than in earlier years. He cuts down on calories and especially does he insist upon a low-fat diet. He also gives you a fresh viewpoint on the digestive processes, sleep, exercise, and plans for retirement.

Mind to Mind, by René Warcollier, edited by Emanuel K. Schwartz, (\$2.50. *Creative Age Press, New York City*) was originally conceived as a lecture, delivered at the Sorbonne in June, 1946, under the title "A Contribution

to the Study of Mental Imagery Through Telepathic Drawing." It is an important book for any one who is interested in psychical research.

Essentials of Food Preparation, by Madge Miller and Mary Barnhart, (\$3.00. *William C. Brown Company, Dubuque, Iowa*) differs from most texts on this subject in that it not only tells how but why. It is intended as a college text but it is an easy book to read and will bring you up to date in many matters of dietetics. Again, it is a most practical gift for the prospective bride.

Our Plundered Planet, by Fairchild Osborn, (\$2.50. *Little, Brown and Company, Boston, Massachusetts*) demonstrates brilliantly and unsparingly that we are following a course which one day will render our good earth as dead as the moon. The author, President of the New York Zoological Society, put it up to all of us to meet this challenge. Of interest to physicians especially is his critical analysis of the relation of our health to our soil.

Daniel, The Prophet, by M. R. DeHaan, M. D., (\$3.00. *Zondervan Publishing House, Grand Rapids, Michigan*) presents 35 simple studies on the book of Daniel by a physician missionary and nationally known radio preacher. The author attempts to study the prophecy in the current interracial tensions. "But go thy way till the end be; for those shalt rest and stand thy lot at the end of the days."

Introduction to Human Physiology, by William D. Zoethout, Ph. D., (\$4.00. *C. V. Mosby Company, St. Louis, Missouri*) is an attempt to make the study of this subject both interesting and practical—hence the emphasis throughout is where it should be—on the maintenance of health.

Proteins and Amino Acids, edited by Melville Sahyun, Ph. D., (\$7.50. *Reinhold Publishing Company, New York City*) emphasizes that there is no subject greater in physiological importance or of greater moment to human welfare than nutrition. Of all the elements involved at the moment, proteins are getting the most attention at the present. It would appear that one can no longer consider that the sole function of protein is the building of body tissue. The living tissues once they are recreated and kept in proper repair, must of necessity enter into relationships with vitamins, minerals, fats, and carbohydrates to get the job of living accomplished.

Heart, A Physiologic and Clinical Study of Cardiovascular Disease, by Aldo A. Luisada, M. D., (\$10.00. *The Williams & Wilkins Company, Baltimore, Maryland*) presents an immense amount of information in 650 large pages.

The author is a brilliant investigator in the pathologic physiological mechanism of cardiac disorders. Here he reviews the current status of those problems in cardiology which are still *sub judice*. In doing so he expresses his own opinions fearlessly while giving us an excellent survey of both European and American thought. No physician can afford to miss this volume.

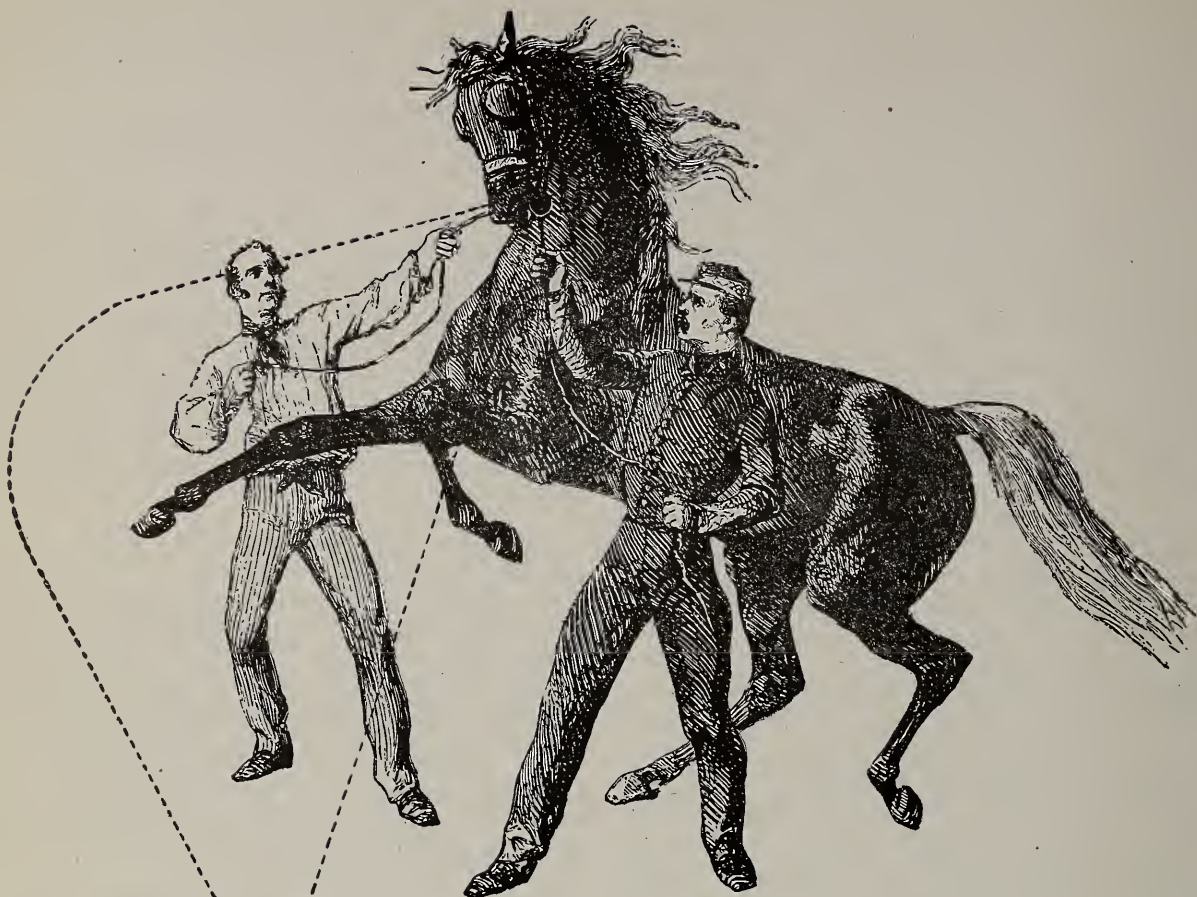
The Sulfonamides and Allied Compounds, by Elmore H. Northey, Ph. D., (\$12.50. *Reinhold Publishing Corporation, New York City*) is one of the monograph series of the American Chemical Society. It attempts to cover the chemical side of the field of chemotherapy. It becomes therefore a standard work of reference when dealing with these "miracle drugs" of which there are now over 5,000 newly synthesized compounds.

Pathology of Tumors, by R. A. Willis, M. D., (\$20.00. *C. V. Mosby Company, St. Louis, Missouri*) represents 20 years' experience in tumors by the Professor of Human and Comparative Pathology in the Royal College of Surgeons, London, and in addition to all else, a record of the author's personal observations and conclusions. The book is addressed primarily to pathologists, research workers, and senior students. As such it is a work of reference to be found beside each of these.

Laboratory Experiments in Physiology, by W. D. Zoethout, Ph. D., (\$3.00. Fourth Edition. *C. V. Mosby Company, St. Louis, Missouri*) has been carefully gone over and many changes have been made to bring it up to date.

Psychiatry for the Pediatrician, by Hale F. Shirley, M. D., (\$4.50. *The Commonwealth Fund, New York City*) is an elaboration of a series of lectures on child psychiatry given at Stanford, and insists that the pediatrician must now give equal attention to the mental as well as the physical health of his little patient. This monograph will be most helpful to those who do concern themselves with this service.

Psychobiology and Psychiatry, A Textbook of Normal and Abnormal Human Behavior, by Wendell Muncie, M. D., (\$9.00. Second Edition. *C. V. Mosby Company, St. Louis, Missouri*) has been revised in the light of current progress (?). The author aptly puts his finger on the tender spot, "There is still too much heat and too little light in our discussions. Case observation lends to generalization; generalization to rigid systematization; systematization to belief; belief to intolerance; and intolerance to ambition to control teaching policy and the few facilities for hospital treatment." The book makes much of the fact that physicians have the primary task to aid human sufferers.



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The Ohio State Medical Journal

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No. 7

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

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Asst. Managing Editor

Collateral Findings and Supportive Therapy in Acne Vulgaris

J. D. WALTERS, M. D.

VARIOUS investigators have mentioned one or more factors in the etiology of acne vulgaris. Urbach and LeWinn,¹ Thompson, Birnberg and Rein,² and Pillsbury, Sulzberger, and Livingood, are among those who consider endocrine pathology as a major cause.

The liver plays a very important part in this dermatosis. It is concerned with vitamin deficiencies and inactivation of excess estrogens.³ Macrocytic anemias respond to injectable crude liver. Marshall⁴ writes that improved liver extract produced satisfactory results in 89 per cent of unselected cases of acne. Marshall also lists four main component features in acne: seborrhea; thickness, induration, and rigidity of the skin; presence of comedones; and eruptions such as macules, papules, pustules, and crusts. He noted that the administration of liver extract cleared the seborrhea first. This was followed by diminution in the thickness, etc. of the skin, making it softer and more elastic. The remaining two components did not clear entirely but showed some benefit from the liver injections.

Stokes and Sternberg⁵ list some of the etiological components in acne as: heredity, hyperactive sebaceous glands, infections, allergy, and endocrines.

The Author

● Dr. Walters, Cleveland, Ohio, is a graduate of Ohio State University College of Medicine, 1931; fellow, American Academy of Dermatology and Syphilology; member, Society for Investigative Dermatology; visiting dermatologist, St. John's Hospital; and head, Dept. of Dermatology, Huron Road Hospital, Cleveland.

Primitive races such as the native Black Africans, Eskimos, Australian Aborigenes and Maoris, had a very low incidence of acne. However, since the Maoris adopted some of our modern methods of living, skin conditions such as acne, have greatly increased.

Although this condition is generally considered a problem of puberty, variants have also been observed. Aitkins reported that three infants (two of whom were males), ranging in age from four to twenty months were so afflicted. Hellier found acne conglobata in a 64-year old male patient.

In the examination of 115 of my patients with acne vulgaris, some of the important factors considered were: endocrine imbalance, circulation, nervous influences, exhaustion, gastrointestinal disturbances, seborrhea, stimulants,

nutritional deficiencies, blood findings, habits, and heredity.

Table I shows some of the office tests performed.

TABLE I

Office Procedures*	Number of Abnormal Cases	Number of Improved Cases	Per Cent of Improvement
Vibratory sensations under 25 seconds	108	73	67.6
Positive histamine reaction**	108	64	59.2
Dark adaptation test (over 5 min.)***	102	82	80.4
Vibratory sensations of skull, diminished	92	84	91.3
Mottled Cyanosis	88	76	86.4
Positive petechial reaction	72	56	77.7
Orthostatic Hypotension ⁶	64	48	75.0
Dilated Pupils	56	14	25.0
Positive Romberg	45	39	86.6
Increased venous pressure (lingual veins)	32	22	68.7

* In addition to the above findings, records also included: pulse, pulse pressures, dynamometer readings, dermatographia, and Achilles and patellar reflexes.
** A 1 to 100,000 dilution intradermally was used in comparison to normal salt solution.
*** Feldman adaptometer was used.

Laboratory tests included basal metabolism, and numerous blood and urinalyses, mentioned in Tables II, III, and IV.

TABLE II

Blood Analyses*	Number of Abnormal Cases	Number of Improved Cases	Per Cent of Improvement
Low hemoglobin (photoelectric)	49	41	83.6
Low red blood cells	37	36	97.3
Low phosphorus	36	28	77.7
High Lymphocytes	32	30	93.7
Hypercholesterolemia	31	29	95.5
Hypoglycemia	26	24	92.3
Hypochromia	25	21	84.0
Low Cholesterol esters	24	22	91.6
Hypercalcemia	22	18	81.8
Low vitamin C	21	20	95.4

* Other important blood tests were: vitamin A, carotene, icterus index, sedimentation rate, prothrombin, fragility of red blood cells, platelet count, alkaline phosphatase, non-protein nitrogen, albumin, globulin, sodium, potassium, sulfur, chlorides, magnesium, serum amylase and serum lipase.

TABLE III

Urinalyses	Number of Abnormal Cases	Number of Improved Cases	Per Cent of Improvement
Albuminuria	39	31	79.5
White blood cells (over 5 per HPF)	36	30	83.3
Erythrocytes	18	16	88.8
Excess carbonates	10	9	90.0
Excess phosphates	10	6	60.0
Indicanuria	8	8	100.0

TABLE IV

Basal Metabolism Rate	Number of Abnormal Cases	Number of Improved Cases	Per Cent of Improvement
Low rate*	24	19	79.1
High rate**	15	12	80.0

* Lowest was minus 44.
** Highest was plus 58.

Particular emphasis in treating these cases was placed on proper diets, liver therapy, correction of habits, and supportive therapy.

Although diets were selected to fit each individual, they primarily revolved around sufficient intake of water, raw fresh fruits and vegetables, organs, lean meats, eggs, poultry, unfortified whole grain cereals, whole milk, some canned fish and sea foods, and small amounts of butter, honey, salt, and unheated vegetable oils. The avoidance of the following was deemed necessary: refined foods (sugar, rice, flour, etc.); processed foods, such as certain cheeses; creams; delicatessen items; artificial and carbonated drinks; fried foods; fat meats; tea; coffee; candy; chocolate and its products; gum; canned fruits and vegetables; and tobacco and alcohol.

Crude liver, heated and unheated, proved very beneficial. This was given orally (Armour's), 1 teaspoon daily, and/or intramuscularly in 1 to 2 cc. doses, once or twice a week. Frequently vitamins B₁ and B₆ were also added; 10 to 15 mgm. of the former were used, while 10 to 50 mgm. were the dosages of the latter. The more seborrhea and comedones there were, the greater was the vitamin B₆ dose. Dilute hydrochloric acid (10 to 25 min. three times a day) helped to reduce the oiliness.

There was a decided improvement when the diets were supplemented with concentrates of natural minerals (derived from vegetable, yeast and cereal sources), vitamins (primarily from vegetables, organs, and yeast sources), and natural endocrine and organ therapy. Patients were advised to get sufficient sleep, to eat slowly and to chew their food well. Anger or nervous tension was to be avoided, particularly during meals.

As the acne began to clear, the endocrine therapy was first reduced, and then stopped. The same procedure was followed for vitamins and supportive agents, until only the nutritional and habit managements were left.

Two representative cases, both females, are given below as illustrations.

CASE NO. 1

M. P., No. 2756, was first seen in March, 1942, at the age of 15. Her face showed large cystic areas, papules, pits, pustules, and comedones. Pallor was prominent, and the patient was generally undernourished and underweight. The condition was diagnosed as acne vulgaris. She was given autogenous and stock vaccines, diet

rules (as referred to above), and such lotions as Lotio Alba and its variants. She also had several abscessed teeth removed. Within three months her condition was improved, and she then stopped therapy and resumed her former habits.

When the acne recurred, she had then received eleven fractional X-ray treatments elsewhere. One month after these were completed she experienced a severe flareup. Two months later, she returned to my office. At that time, the following observations and information were obtained: Nervous factors: Cried easily; excitable; light sleeper; nervous; impatient; easily annoyed; had insomnia and hyperesthesia. Endocrines: Breasts itch before menses, especially the nipples. Gastro-intestinal disorders: Poor appetite; belching; craving for sweets; halitosis. Circulatory disorders: Hands cold; can't stand cold weather; often feels chilly. Ocular disorders: Circumcorneal injections; conjunctivitis; eyes smarted. Diet: Used alcohol, tea, and excess amounts of sugar; skipped meals; avoided eating organ meats. Urinary system: Nocturia; polyuria at day time. Miscellaneous skin findings: Dandruff; oily hair; itchy scalp; rough cuticles; brittle nails; hang-nails; fissured and serrated tongue; atrophic papillae; large wheals when mosquito bitten; unable to get tanned in the sun. Heredity: Brother has acne vulgaris. Office tests: Orthostatic hypotension; diminished vibratory sensations.

THERAPY

After continuing on the afore-mentioned diet for several months, her condition improved. Her diet was supplemented by the use of 5 gr. whole pancreas; 1 gr. bile; 15 min. hydrochloric acid three times a day; 2 gr. chlorophyll; 1 ounce daily of plain cod liver oil; 5 gr. whole ovary; and B Complex (having a base of rice bran, yeast, liver, and wheat germ).

CASE NO. 2

P. T., No. 4891. This 18-year-old girl presented an acne vulgaris when first seen by me in November, 1944. Besides the usual pits, comedones, papules, pustules, cysts, scars, and nodules, several large serosanguinous blebs were present on both cheeks and on the chin. History, signs, and symptoms were as follows: Nervous factors: Cried easily; restless; nervous; excessive hyperesthesia; nail-biter; couldn't tolerate blackboard noises. Endocrines: Gained weight easily; had premenstrual flare-ups; dysmenorrhea; profuse menses; clots during menses. Gastro-intestinal disorders: Abdominal pain; bleeding gums; missing teeth; numerous fillings in teeth; had frequent heavy dreams; felt bloated. Circulatory disorders: Sleepy after meals; blushed easily; bruised easily; yawned frequently; frequent headaches; tender calves; extremities felt tired and heavy. Respiratory disorders: Sinusitis; frequent colds and sore throats. Ocular disorders: Eyestrain; blurred vision; dilated pupils. Diet: Used a great deal of candy, coffee, pastry, carbonated drinks, sugars, fried foods, and ice-creams; included no eggs nor raw vegetables in her diet. Miscellaneous skin findings: Oily hair; rough and ragged cuticles; brittle and slowgrowing nails; "moons" missing on nails; hang-nails; freckles easily. Habits: Ate rapidly; skipped meals; did not have sufficient fresh air.

Laboratory Tests: Abnormal findings:
Basal Metabolism Rate—+38 per cent
Blood Sugar—70.0 mgs. per cent
Serum Calcium—8.3 mgs. per cent
Plasma Vitamin C—0.4 mgs. per cent
Red Blood cells—3,650,000 per cu. mm.

Hemoglobin—69.0 per cent

Polychromia

Hypochromia

Anisocytosis

Urinalysis: Albumin 1+

Office Tests: Abnormal findings: Diminished vibratory sensations; positive histamine flare (1:100,000 dilution); hyperactive patellar reflexes; mottled cyanosis; orthostatic hypotension.

THERAPY

Excellent results were obtained from: proper diet; 2 gr. Armour's Suprarenalin Concentrate, twice a day; 5 gr. insulin-free pancreas; 5 gr. whole ovary; 15 min. dilute hydrochloric acid, three times a day; 100 mgms. vitamin C, three times a day; 1 t. plain cod liver oil daily; B complex; Chlorophyll; natural minerals; natural vitamins; organs (kidney, brain, stomach); injections of liver.

DISCUSSION

In this series, 89 patients were females and 26 were males. Approximately two weeks on the proper routine were sufficient to bring about an improvement in the seborrhea and pustule formation, and a diminution in number and size of the papules. The female patients were more cooperative with respect to diet and habit correction, although both groups collaborated to a great degree on the supplementary medication. It is necessary to continue supportive therapy several months after the lesions have disappeared, otherwise recurrences take place in minor forms. Fifteen males and 43 females in the group that cooperated have remained clear after four months of therapy, by remaining on the prescribed diet. Failures occurred in some of the cooperative types (11 females and 6 males), but occupations, and problems at home were contributory factors. It is my impression that the use of larger doses of the various preparations would have been even more beneficial for the latter group.

When only X-ray and topical medication were employed, recurrences were not infrequent. As other measures were added, as, for example, the management of diet and habits, endocrines, organs, natural mineral and vitamin therapy, beneficial results were apparent and lasting. Less supportive items were administered as the complaints and symptoms disappeared. At the present time, correct diet and habits can keep the patient free from eruptions when a body balance is approached.

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Non-Tuberculous Pulmonary Calcification

JOHN A. PRIOR, M. D.

FOR many years most pulmonary calcifications have been considered the direct result of an antecedent tuberculous infection. Provided the number or area of these calcifications exceeded certain arbitrarily established limits, and irrespective of apparent clinical quiescence, radiological evidence of pulmonary calcification was made the basis for the rejection from service in the Armed Forces of thousands of selectees during World War II. In very recent years the possible relationship between calcified lesions of the lungs, especially as they occur in the Eastern Central states,* and the rare fungus disease, histoplasmosis, has been a subject of growing interest to investigators and clinicians alike. Although the relationship existing between histoplasmosis or other possible non-tuberculous etiologic agents and pulmonary calcification cannot be definitely and finally stated, recent studies would indicate that some of the fundamental concepts previously held relating to pulmonary calcification will need revision.

It has been assumed generally that it is only the exceptional individual previously infected with tuberculosis who fails to react to tuberculin. Throughout most of the country, survey studies tend to show a close correlation between the tuberculin reaction and pulmonary calcifications. However, repeated studies during the past decade, particularly from the Eastern Central states, have demonstrated that there are a large number of people who have calcification in the lung fields, but who do not react to tuberculin. In 1938, Gass, et al.,¹ reported from Tennessee that "a remarkable tendency toward the deposition of calcium in lung fields or in tracheobronchial lymph nodes had been noted and it seemed apparent that calcified lesions as demonstrated by X-ray are present in a greater proportion of individuals than has been reported in other parts of the country." Studies conducted in Williamson County called attention to the large number of people who had pulmonary calcifications but failed to react to tuberculin. Of those with calcified lesions in their lungs, only 39.4 per cent showed a positive tuberculin test.

In the same year, Nelson, Mitchell, and Brown² noticed that a relatively large number of children in Southern Ohio showed calcified lesions in the chest, though only 42.9 per cent reacted to the tuberculin test.

* The term "Eastern Central states" is meant to include West Virginia, Ohio, Indiana, Illinois, Kentucky, Tennessee, Iowa, Missouri, and Arkansas.

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The Author

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In 1940, Lumsden and Dearing,³ studying tuberculosis mortality, selected for more intensive study Coffee County, Alabama, as a representative region of low, and Giles County, Tennessee, as a representative area of high acid-fast mortality. Chest X-rays and tuberculin skin tests were given to approximately 5,000 residents of each county. In Coffee County 20.4 per cent of whites and 32.5 per cent of Negroes reacted to tuberculin, and in Giles County 25.2 per cent of whites and 43 per cent of the Negroes. Although the difference in incidence of tuberculin reactors between the two areas was not great, pulmonary calcification was reported to be 40 times more frequent in whites in Giles County than in Coffee County and 30 times more frequent in Negroes. These authors carried out similar studies in Kentucky, Ohio, and Indiana, and a marked variation in the incidence of pulmonary calcified lesions over the five states was noted. They investigated the relationship of pulmonary calcifications and limestone formations in the several localities, but the results were inconclusive.

ROSS COUNTY

Olson, Wright, and Nolan,⁴ in studying residents of Ross County, Ohio, found that 49.4 per cent had calcified lesions of the lungs, of whom only 17.4 per cent reacted to tuberculin. Ascaris infestation was explored as a possible cause of the calcifications, but these authors were unable to determine any relationship. They concluded that pulmonary calcifications in the tuberculin non-reactors should not be interpreted as evidence of tuberculous infection, but that some as yet unrecognized infection could produce calcified lesions resembling those of primary tuberculosis.

In 1943, Long and Stearns⁵ reviewed 53,400 X-rays of Selective Service inductees and discovered a distinct variation in the incidence of pulmonary calcifications occurring in residents of various sections of the country, from a low

of 6 per cent in Oregon to a high of 28 per cent in Kentucky. Their figures showed that in the Eastern Central states: there was an unusually high incidence of pulmonary calcifications—considerably in excess of other regions; the greater prevalence of pulmonary calcification was attended by larger and more numerous lesions than have been seen generally throughout the nation; and there was an increased tendency for disseminated miliary calcified lesions. It was the opinion of these authors that in this East-Central geographic zone the pulmonary calcifications were greater than expected on the basis of tuberculin studies only.

CORRELATION

It is obvious that the area in which Long and Stearns reported an excessive incidence of pulmonary calcification corresponded rather well to the area in which there were many people who failed to react to tuberculin but did show evidence of calcification in their lungs.

At much the same time Aronson, Saylor, and Parr⁶ and Smith⁷ and his associates had been studying calcified pulmonary lesions and their relationship to a fungus disease, coccidioidomycosis. In 1943, Smith summarized this work, stating that in the Southwestern states, particularly California, a considerable amount of pulmonary calcification occurs in those who do not react to tuberculin and that the incidence of the pulmonary calcifications tends to be in excess of the amount expected on the basis of tuberculin reactors. Evidence presented shows that in areas where coccidioides immitis is endemic, infection with this fungus will produce a "primary complex" in the lung that goes on to calcification and is indistinguishable from that due to tuberculous infection. Of those who had calcified lesions in their lungs but failed to react to tuberculin, most reacted to skin test doses of coccidioidin, a filtrate of cultures of coccidioides immitis. In this same year in a communication to Christie and Peterson,⁸ he called attention to the possibility that some infection (probably fungus) resulted in a situation in the Eastern Central states similar to that of the pulmonary calcifications that occur in the Southwest. Further, he pointed out that this region of excessive pulmonary calcification in tuberculin non-reactors corresponded with the endemic area of histoplasmosis, a rare fungus disease which seldom has been diagnosed antemortem and has been considered universally fatal.

THE SKIN TEST

In 1945, Palmer⁹ reported the results of the first extensive clinical study with the histoplasmin skin test which had been developed by Van Pernis, Benson, and Holinger¹⁰ and by Zarfonetis and Lindberg.¹¹ Histoplasmin is a

filtrate of broth cultures of the fungus, histoplasma capsulatum, which is the etiologic agent of histoplasmosis. 0.1 cc. of a 1:1000 dilution is injected intradermally and the skin test is interpreted after an interval of forty-eight hours. Three thousand one hundred five student nurses in several widely separated cities were surveyed by means of chest X-rays, tuberculin and histoplasmin skin tests; 9.5 per cent of the group showed evidence of calcified pulmonary lesions. A higher degree of correlation was seen to exist between the pulmonary calcifications as they occur in the Eastern Central states and a positive histoplasmin reaction than with tuberculin. Of those showing calcified lesions in their lungs 21.4 per cent reacted to tuberculin and 70.1 per cent reacted to histoplasmin; 8.5 per cent of individuals with pulmonary calcifications failed to react to both tuberculin and histoplasmin. Among the large group who did not react to either antigen, only 1.2 per cent showed evidence of pulmonary calcification. He pointed out that the area in which there is a high incidence of histoplasmin reactors corresponds to that in which pulmonary calcifications are unusually frequent. His work suggested that there may be a widespread benign form of histoplasmosis, as well as the more generally recognized fatal variety. It is of interest to note that coccidioidomycosis and tuberculosis, both of which may be a frequent cause of benign calcified pulmonary lesions as well as result in a serious disease, have undergone a similar evolution of concept.

Later the same year, Christie and Peterson⁸ reported radiological evidence of calcified lesions in the lungs of 43.6 per cent of a group of children studied in Tennessee; 25 per cent reacted to tuberculin and 73.5 per cent to histoplasmin. Their results confirmed the better correlation between pulmonary calcifications occurring in that region and a positive histoplasmin reaction than with tuberculin. Also they noted that the calcifications associated with the histoplasmin reaction tended to appear earlier in life than those in tuberculin reactors.

NURSES

In 1946, Palmer¹² reported the results of a nationwide study of 10,580 student nurses, showing the geographic distribution of their sensitivity to histoplasmin. His figures reveal a very high incidence of histoplasmin reactors (68.3 per cent) in the Eastern Central States. Contiguous areas are much lower and the region of lowest incidence is in the Pacific Northwest (1.4 per cent). Ohio has 60.2 per cent reactors. Within several states, e.g., Ohio and Kansas, which tend to be on the border of this region of high incidence of positive reactors, a definite pattern of incidence has been noted. As one

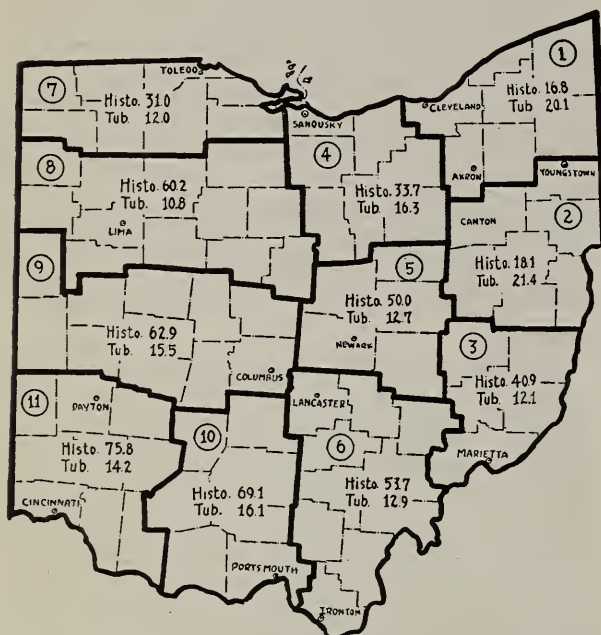
moves across each state away from the center of this area, the incidence of positive reactors decreases markedly.

OHIO

Our studies¹³ in Ohio have confirmed in general this geographic pattern of the incidence of positive histoplasmin reactors. Five thousand and eighty-seven Ohio State University freshmen and student nurses training in Columbus, all of whom were lifetime residents of some one county, were surveyed with chest roentgenograms, tuberculin and histoplasmin skin tests. Every county in the state was represented in the group studied. Approximately one third were females. The average age was 21 years for males and 19.4 for females.

STUDENTS

The highest incidence of positive reactors, 75.8 per cent, is found in students residing in the extreme Southwestern portion of the State, area 11 (Map 1). As one moves to the North



Map 1. Per cent of reactors to histoplasmin and tuberculin among students who were lifetime residents of Ohio counties by geographic area (Ohio State University freshmen and student nurses training in Columbus).

Because the rates for each of the 88 counties differed according to a geographic pattern and because the number of students from any one county was often too small to provide a reliable rate for the county, contiguous counties with similar histoplasmin reactor rates were combined into 11 areas.

and East, a marked decrease in the incidence of histoplasmin reactors is seen, and the lowest, 16.8 per cent, is in the Northeastern section, area 1. Thus, it is seen that the incidence of reactors in area 11 is more than four times that of area 1. Further it is of interest to note that our figures show that there is a higher rate of reaction to histoplasmin among lifetime farm residents than among other students from Ohio. The rate is an average of 9.5 per cent

greater than for the remainder of the group. The reactor rates for males are approximately 5 per cent higher than those for females.

No similar geographic differences are seen in the distribution of positive tuberculin reactors (Map 1). Sixteen per cent of the students tested reacted to tuberculin. The incidence of reactors follows the usual pattern, dependent largely upon socio-economic conditions. In contrast to the incidence among histoplasmin reactors, there were fewer reactors to tuberculin among lifelong residents of farms than in the remainder of the group.

In a study of 113 individuals showing disseminated miliary pulmonary calcifications, High, Zwerling, and Furcolow¹⁴ found 96.3 per cent positive histoplasmin reactors, while only 10.2 per cent reacted to tuberculin; 3.5 per cent reacted to neither antigen. None reacted to tuberculin alone. It was the author's opinion that disseminated pulmonary calcifications are seldom the result of infection with tubercle bacilli, as judged by the tuberculin reaction, but that the agent producing histoplasmin sensitivity is probably a more frequent factor in the production of such lesions.

THE HISTORY OF THE DISEASE

Historically the disease histoplasmosis has not been an important one. It was first described by Darling¹⁵ in 1906 as a fatal disease of tropical America. The causative agent he called histoplasma capsulatum. Subsequent studies by DaRocha-Lima¹⁶ and DeMonbreum¹⁷ have identified this organism as a fungus. It was not until 1926 that histoplasmosis was found in this country, and although more and more cases are being reported, it still remains a rare disease. In 1945, Ziegler¹⁸ reviewed the literature and could find a record of only 79 cases, although there undoubtedly are others that are unreported or undiagnosed. Although worldwide in distribution, more than half of the reported cases have occurred in the Eastern Central states. There has been a marked increase in the number of cases reported since 1939. Opinion is divided as to whether this is the result of better diagnosis or represents an actual increase in incidence.

Histoplasmosis is characterized by irregular fever, weight loss, digestive disturbances, diarrhea, marked hepatomegaly, splenomegaly, generalized lymphadenopathy, with anemia and leukopenia. Ulcerations of the intestinal tract occur in more than half of the cases, and similar lesions are present on the skin, lip, pharynx, larynx, and penis in about one third. X-ray of the lungs may reveal moderate peribronchial infiltration.

DIAGNOSIS

The diagnosis can be made during life, but is usually very difficult. It can be established

only by identifying the fungus in the large mononuclear cells of blood films, in tissue biopsy, in cultures of blood, sputum or urine, and by guinea pig or mouse inoculation.

The specificity of the histoplasmin skin reaction has been questioned. Emmons, Olson, and Eldridge¹⁹ have called attention to cross reactions of histoplasmin with antigens from other fungi, particularly blastomyces dermatitidis, and to a lesser extent, haplosporangium parvum. It is their view that histoplasmin at present cannot be accepted as a specific diagnostic antigen. McLeod, et al.,²⁰ share this view in reporting two patients with histoplasmosis, diagnosed antemortem, in whom the histoplasmin skin reaction was negative. The authors state, however, that such a finding may represent a terminal anergy, since both patients were in extremis at the time the skin test was applied. Furcolow²¹ states that he soon is reporting nine patients in whom the diagnosis of histoplasmosis was established antemortem. Six had a definite positive reaction to histoplasmin. The three patients, who failed to react, died very shortly thereafter, two of them within a week following the application of the skin test.

CONCLUSIONS

Although some question remains as to the specificity of histoplasmin, it would seem that the following conclusions are justified:

1. In the Eastern Central portion of the United States, there is a better correlation between pulmonary calcifications and a positive histoplasmin reaction than with a positive intradermal tuberculin test, and in cases of disseminated pulmonary calcification there is an even higher incidence of histoplasmin reactors.

2. This same geographic area in which there is excessive pulmonary calcification with not infrequent miliary distribution corresponds rather closely to both the endemic area of histoplasmosis and the region of high incidence of histoplasmin reactors.

3. The histoplasmin reaction represents some previous experience, probably infectious and possibly representing a benign form of histoplasmosis or other disease of common antigenicity, resulting frequently in the formation of pulmonary calcifications.

4. The concept of the etiology of pulmonary calcifications needs revision. Although many are the result of a true tuberculous infection, calcification may also occur as the result of benign forms of coccidioidomycosis and histoplasmosis (or other closely related agent or agents with similar antigenicity).

5. In view of the growing awareness of the non-tuberculous nature of at least some pulmonary calcifications, the use of this finding as a

basis of judgment of physical fitness for military service may need revision.

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Correction in April Issue

We regret that in the article on "Reversible Heart Disease," published in the April issue of *The Journal*, electrocardiograms Nos. 4, 5, 6, and 7 were upside down and not properly placed over the captions. No. 4 should be No. 7; No. 5 should be No. 6; No. 6 should be No. 5; and No. 7 should be No. 4. Responsibility for these errors is mutually shared by the Engraver for disregarding instructions in mounting the electrocardiograms; the Editorial Office Staff for overlooking this error; and the Author for not detecting the error when he o.k'd the proof.

Some Further Observations on the Prognosis After Coronary Occlusion

H. C. KING, M.D.

IN the May, 1937, issue of *The Ohio State Medical Journal* I reported some observations on the prognosis after coronary occlusion based on the outcome in 62 cases. Since the publication of this article there has been much water over the proverbial dam. To me this difficult problem has become a medical hobby. Many better qualified observers have published their conclusions and I should hesitate to bring my material up to date except for the reference to my original article by Fisher and Zuckerman in the *Journal of the American Medical Association* (Vol. 131, No. 5, 385).

A MOST DIFFICULT PROBLEM

Probably there is no more difficult problem in prognosis in all clinical medicine. Just as soon as you have some factor in the problem settled a case comes along to upset your theory. Levy admits that "there is no satisfactory clinical test which will measure the functional capacity of the coronary circulation or, indeed, of the myocardium itself." We do not feel that the recently published test of breathing a mixture of oxygen and nitrogen is either safe or efficient. An exercise test in cases of apparent angina of effort preceding an electrocardiogram is sometimes of value, but must be carried out with great care.

The present report adds the observations based on 100 consecutive cases observed since the original article. All cases included were proven to have suffered coronary occlusion, either by typical electrocardiogram, autopsy findings, or both, and, in every case, a typical clinical picture. No questionable cases were included, nor any in which the outcome could not be determined.

As to age incidence the oldest was 72; youngest was 35; and average age was 56. Sex incidence showed males, 81, or 81 per cent; females, 19, or 19 per cent. Length of life after initial occlusion: Longest, 11 years; average, 28 months. I have observed several cases, not included in this series, who have outlived this time.

There is no question but what Wearn and Middleton are right in asserting that the younger the individual stricken with the closure of a coronary artery the better the outlook, because the better collateral circulation provides a better protection for the myocardium. Age, however, is not always a matter of years,

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and, again, all rules do not hold. We have, in these series, seen comparatively young patients die within a year of the initial attack and Mr. B. died suddenly three months after his initial occlusion, aged 35 years.

As to recurrent attacks, 22 per cent had another attack within two years. It seems the older the patient the more likely an early return of trouble, although there were many exceptions to this rule.

Mortality as to attacks: Immediate mortality (sudden death), 8 per cent; with initial attack, 20 per cent. Followed for a minimum of five years—60 per cent had one attack with a mortality of 32 per cent; 14 per cent had two attacks with a mortality of 64 per cent; 9.2 per cent had three attacks with a mortality of 78 per cent. Three cases died suddenly, getting out of bed against advice.

DEATH WITH FIRST ATTACK

When we come to analyze the number of cases who die suddenly in the first attack we run into some difficulty. It is hard to determine the percentage who have had previous warning by anginal pain. So often the typical precordial discomfort is turned off lightly and ascribed to "gas" or "indigestion." Many areas of healed infarction are found at autopsy where no previous attacks of closure were noted. Our impression is that a large number of patients who suffer coronary occlusion have had previous warning, if heeded. Some might be forewarned by a complete cardiac study, while others would pass the test with a good grade.

In order to evaluate the outlook on the basis of signs and symptoms observed immediately after the attack let us consider the following.

A marked degree of shock immediately following the occlusion is of serious importance. A marked and persistent fall in systolic blood pressure should be regarded as indicating the

occlusion of a large branch of one of the coronary vessels, with the outlook in keeping. In the same category should be considered a high fever a few hours after the attack and, especially a persistent high fever for more than 48 hours. A high white cell count is often encountered and the higher the more serious the outlook, on the whole. A high sedimentation rate of the R.B.C. is slower in appearing and often remains high for some time, even in favorable cases. In those cases which do well we expect pain to disappear rapidly after the initial seizure with sedation and rest in bed. A persistent or recurrent typical pain, with the patient completely at rest, indicates a serious outlook in our experience. Let me emphasize this point. Among the cardiac findings which cause us great concern are cardiac dilatation, gallop rhythm (especially serious), and pulses alternans.

Ventricular tachycardia was encountered several times where the abnormal rhythm was of short duration. In one fatal case it persisted over a week in spite of intensive therapy. Auricular tachycardia may cause early symptoms of failure if it persists. This was encountered once with signs of congestive failure within a period of hours and death a few weeks later. An attack of pulmonary edema is always serious and, shortly after an occlusion, indicates a likely fatal issue, although I have seen such a case living well beyond the ten-year limit. This all goes to show how difficult the problem really is. Congestive failure observed at any time during convalescence shortens the expectancy for length of life.

ARRHYTHMIA

Various types of cardiac arrhythmias may indicate a poor prognosis. Numerous ventricular premature contractions after an occlusion are of serious importance. More serious are such premature beats from more than one focus. Ventricular premature contractions which increase in frequency with exertion are more likely to be serious. Auricular premature beats are not common in our experience, but are more likely to be serious. Auricular fibrillation appearing early after an occlusion probably indicates serious damage to the heart, developing later, it does not seem to influence the outlook materially. A recent case with an occlusion in September developed fibrillation during convalescence and successfully underwent an operation for strangulated hernia in December.

Angina pectoris probably precedes coronary occlusion in one-third of the cases. It is extremely difficult to estimate this figure for we find so many cases where the affliction is not admitted or, more often, its typical symptoms are ascribed to other causes, especially to the digestive tract. "Just gas," the patient says. Sudden death in occlusion seems to us to occur

more often in cases with preceding angina. More cases with a preceding history of angina die suddenly during the first occlusion. In 9 per cent of our series the angina disappeared after the occlusion, in 29 per cent angina occurred both before and after occlusion, while in 8 per cent the preceding angina did not reappear after the patient became ambulatory following coronary occlusion.

HYPERTENSION

Of the 100 cases, 35 showed a preceding hypertension. The incidence of hypertension in the female group in our series was 30 per cent higher than in the males. We have long held that coronary occlusion does not often occur in women under fifty without a preceding hypertension. Again there are marked exceptions and the syndrome has been observed in young females. A hypertension persisted after the attack in 23 per cent and, if the pressures remained quite high, the patients did not seem to have as good an outlook. In patients with a previous hypertension a persistent low blood pressure after recovery gave us concern and these patients were given longer periods of rest in bed. On the whole they did not seem to do much worse than the group as a whole. But I should caution with a persistent low systolic pressure.

Of the 100 cases of infarction, 64 were anterior and 35 were posterior, while one was a case of infarction of the lateral wall of the left ventricle. For some time we were inclined to share the opinion voiced by Wolfert some time ago that anterior infarctions were more serious than those on the posterior surface of the heart. Willius of Mayo denied this difference. As we survey the present series this difference in prognosis does not seem to be so significant. Only ten days before these lines were written we saw, in consultation, a case of posterior infarction with profound shock, persistent dyspnea and death within thirty-six hours, and in a patient of forty-five years. And as we go over our manuscript we note the death of one of our best medical friends, five days after a single small posterior infarction.

THE ELECTROCARDIOGRAM

It is also difficult to base the prognosis on the findings in the electrocardiogram. On the whole, persistent small QRS deflections are more likely to be found in cases with a poor outlook for length of life. Too much emphasis, however, should not be placed upon this finding. Bizarre records are serious. A return of the electrocardiogram to normal is a good omen, while persistent findings, typical of a recent occlusion, are bad. The development of bundle branch block at any time after occlusion shortens life expectancy. Developing a short time after

the acute attack, the outlook is especially bad, whereas its appearance months or years later may permit of several years of life. Each case must be a problem unto itself.

We may now study the effect of treatment on prognosis. I am not sure that any marked improvement in treatment in the past ten years has materially influenced prognosis. If the mortality rate has improved it is likely that the doctor is more keenly aware of the syndrome and that diagnosis and treatment are more prompt. On the whole, with efficient treatment, the prognosis is most influenced by the extent of the damage done, namely, by the size of the infarcted area. Papaverine, among the newer remedies, has not seemed to us to be of great value. Quinidine has not been given routinely to prevent ventricular fibrillation, as recommended by Levine, but has been valuable in multiple ventricular extrasystoles and in ventricular tachycardia. Surely, of course, digitalis is of value any time in failure. After relief of the initial pain by morphine, small amounts of phenobarbital have proven of value in allaying restlessness and apprehension. Nearly all our patients received alcohol in small repeated doses during convalescence and have been advised to continue taking two or three drinks daily. Oxygen is not often immediately available, but its use is one of the real advances in treatment and may be life saving.

AFTER-CARE

As to the general care after recovery, we recommend a sensible routine, a life of moderation, plenty of relaxation, long hours of rest, and frequent vacations. We must seek a middle ground between making the patient introspective and allowing him to overlook the warnings of trouble ahead. Our experience agrees with that of Masters that patients live at least as long if allowed to continue their work. Tobacco should be kept at a minimum, especially where smoking results in immediate changes in the electrocardiogram. There is some question as to the importance of the drastic reduction of tobacco in the elderly.

Not enough has been written about the temperament of the patient. The man with coronary disease should take life in its stride, should live each day unto itself and not fuss or fume at people or incidents, such as we all encounter.

OPERATIONS

The patient with coronary artery disease and the one who has had a previous occlusion presents a special problem when surgical operation and anesthesia become necessary. The best recent summary of the problem is that of Ernstone in the *Cleveland Clinic Quarterly* for October, 1946. He has had an unusually good op-

portunity to observe these patients under ideal conditions, both as to medical assay and as to surgical therapy. Our much more limited experience would surely uphold the conclusions he reaches in his summary.

It goes without argument that these victims of coronary disease are not average surgical risks. We should not subject them to unnecessary operation. Necessary operations are of two kinds, one is needed at once to save life and without it the patient will surely die. In these cases there is no argument; we take the risk. The other type is also life saving, but may be delayed a short time while the patient is studied and prepared. In patients who have an enlarged heart, hypertension, any sign of congestive failure or auricular fibrillation, digitalis should be administered preoperatively until the ventricular rate is reasonable and the patient digitalized. If operation is urgently needed in this group digitalize rapidly by parenteral administration. Anesthesia, if possible, should be local. If general anesthesia is required, skillfully administered gas and ether is safest. Spinal anesthesia should be avoided because of the attendant fall in blood pressure. We recently saw a near fatal result of such a case. With these considerations in mind you will be surprised, as I have, how often these patients ride through.

One final paragraph must be devoted to something which has long been close to my heart. When an operation which is not absolutely necessary, such as that for hernia or pelvic repair, is contemplated in a patient with coronary disease one should do two things. The necessity of the operation should be weighed against the patient's condition and his probable life expectancy. He should be thoroughly studied and prepared and the family informed of the risk. One case will illustrate my point. Some years ago a patient of mine who had suffered a coronary occlusion and, for two years, had a left bundle branch block, was subjected to a pelvic repair in the clinic of a large hospital. She lived just two months after the operation. We would probably reduce our mortality rate if we did routine electrocardiograms on all surgical prospects past the age of forty.

Erythema Nodosum

Even if not more than two-thirds of the cases of erythema nodosum are associated with a tuberculous primary infection, it is obvious that every tuberculin-positive case must be treated in private practice as a possible expression of tuberculosis until thorough examination has shown that this possibility can be ruled out. The best guide to the etiological diagnosis seems to be the vesicular tuberculin reaction. Hans Jacob Ustvedt, M. D., *Tubercle*, Dec., 1947.

Palindromic Rheumatism—Effective Treatment with Gold

MATTHEW GINSBURG, M.D.

IN 1941, Hench and Rosenberg¹ wrote a masterful, detailed and descriptive article on a clinical syndrome which they labelled "palindromic rheumatism." This title was used because it described an entity which was different from other forms of joint involvement. "Palindromic" means recurring or subsiding without coming to a head. "Rheumatism" implies not only joint involvement but also the peri- and para-articular tissues. According to these investigators, palindromic rheumatism is characterized by "multiple afebrile attacks of acute arthritis and periarthritis and sometimes also of para-arthritis, with pain, swelling, redness, and disability generally of only one but sometimes of more than one, small or large joint, in an adult of either sex. The attacks appear suddenly and develop rapidly. They generally last only a few hours or days and then disappear completely, but recur repeatedly at short or long irregular spaced intervals. Despite the frequent recurrences and the transitory presence (in some cases at least) of an acute or subacute inflammatory polymorphonuclear exudate in the articular tissues and cavity, little or no constitutional reaction or abnormality is revealed by laboratory tests, and no significant functional, pathologic or X-ray residue occur even after years of disease and scores of attacks."

Cain² in 1944, reported such a condition in a 23-year-old soldier from Ohio. Here, the attacks involved only one joint at a time and heat afforded some relief. The first attack began at the age of 16 and recurred once or twice a week. Of particular interest is the fact that no definite etiologic factor was uncovered nor was an effective therapeutic agent described. In the seventh edition of his book, Cecil³ states that in one case of palindromic rheumatism excellent results were obtained with small doses of gold. I wish to report a case in which there has been complete relief of all symptoms following gold therapy, in the hope that others may try this agent and report on its effectiveness.

CASE REPORT

The patient is a white male, aged 39, an office worker, who presented himself in my office April 22, 1941, complaining of pains in both shoulders and pain and swelling of the left index finger. In 1939, he first noticed the sudden onset of pain in both shoulders, which would come and go and seemed to be worse in the Spring of each year. There was no redness nor swelling at this time and the application of heat would give relief. The attacks would come

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on abruptly and last for a few days leaving no residual effects. Even though there was pain and stiffness, the joints were not tender to touch. His general physical condition was good, there were no chills nor fever and no history of rheumatism in the family. In 1941, other joints became involved and heat was not as effective as in the past.

Physical examination revealed a tall, thin, white male in a good nutritional state; blood pressure 114/70; temperature 98; pulse 70; respirations 18. Teeth, tonsils, sinuses, and prostate were normal. Heart, lungs, and abdomen were normal. There was mild swelling of the proximal interphalangeal joint of the left index finger. There was no redness nor tenderness to touch.

LABORATORY FINDINGS

Hemoglobin 80 per cent; Red blood count 5,000,000; white blood count 8750; polys 69; stabs 4; lym 20; monos 2; eosino 5. Sedimentation rate, 15 mm/hr (quiescent disease). Urinalysis, alkaline; pH 7.5; albumin and sugar negative; large amounts of amorphous phosphates. Blood uric acid, 3.8 mgm per cent. Skin tests for allergy were negative. Brucellergin skin test was negative. X-rays of both hands revealed no bony changes.

Clinical course: Under symptomatic treatment there was no particular improvement. Analgesics relieved the pain temporarily. Almost every joint was involved at one time or another. Foci of infection were investigated without relief. The following procedures and medications were tried unsuccessfully: prostatic massage (smear normal); vitamin B orally; reduction of fluids; ammonium chloride; Oxo-ate B; vitamin A in large doses; rheumatoid vaccine in vein; sulfathiazole; histamine subcutaneously; empirin compound with codein; colchicine (caused diarrhea); diet for gout; KI; food diary; multiple vitamins; whole blood in the muscle; discontinue smoking; ephedrine orally; vitamin K by mouth and in vein; elimination diet; hapamine; torantil; acid-ash diet; physostigmine-atropine injections; glutamic acid tablets; Curtasal; staphylococcus toxoid; benadryl; vitamin D in large doses (he took this himself).

Changes in weather, such as damp and cold did not seem to affect the joints although the patient noted that on a trip to Florida in January, 1946, the joint symptoms gradually diminished as he drove south. When he reached southern Georgia, the pains were gone and did not recur while in Florida. However, on returning home, there was a recurrence of all symptoms and

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signs when he reached the State of Ohio. In February, 1947, he drove to Florida again and all joint symptoms were relieved when he reached St. Augustine. He was symptom-free until two days after his arrival home when the usual pains, swelling, and stiffness recurred. At no time were subcutaneous nodules noted.

Joints involved were shoulders, fingers, wrists, hips, great toe, elbows, temporo-mandibular, cervical vertebrae; also involved were tendons of knee joints, tendons of toes, subdeltoid bursae regions, pubic bursae, bursae over greater trochanters, immediately below both internal malleoli patellar regions. At the beginning, there was no redness of the joints, but this developed later. Pain was not limited to the joints themselves, but involved areas around and near them. Stiffness was a constant complaint.

A chronological account of his progress follows:

September 12, 1941: Developed redness for the first time. Involved knuckles of right hand.

January 9, 1946: Attacks are shorter and not so painful. Was free of joint pain in Florida.

February 15, 1946: Bursae seem to be involved. Notices pain in area before any swelling occurs. By the time swelling develops, the pain is gone.

February 20, 1946: Proximal interphalangeal joint right second finger is swollen and stiff.

February 27, 1946: Sudden pain below both internal malleoli. Also pain in midcervical region aggravated by deep breathing or cough. Never had pains in these areas before.

March 27, 1946: No pains. Simply stiffness after resting for a short time. Walking relieves stiffness.

April 19, 1946: Symptoms have changed considerably. Stiffness occurs mostly at night. Does not interfere with sleep. Shoulders and back of knees are areas most frequently involved now.

April 29, 1946: Swelling of plantar surfaces of both feet.

June 5, 1946: X-ray of fingers negative for bony changes.

June 10, 1947: Pain and stiffness of fingers, worse in right hand. Swelling. Joints become stiff if in one position for a short period of time. Patient started on gold therapy. Given 10 mgm. Solganal B in muscle. (Blood count and urine normal at this time).

June 17, 1947: Improved. Swelling in fingers is reduced by 50 per cent. Has less pain when shaking hands. Less stiffness in fingers. Hips, knees and feet are stiff particularly after rest. Generally feels good. Given 10 mgm. Solganal B in muscle.

June 24, 1947: No pain nor stiffness in fingers. Has stiffness in hips and legs after rest. Given 25 mgm. Solganal B in muscle.

July 1, 1947: Condition unchanged; 25 mgm. Solganal B in muscle.

July 8, 1947: No pain and less stiffness in all joints; 30 mgm. Solganal B in muscle.

July 18, 1947: Greatly improved. Swellings gone. Much less stiffness in joints. Can get up from sitting position and move immediately, whereas before had to wait in the standing position for a moment before being able to start walking. Given 30 mgm. Solganal B in muscle.

July 25, 1947: Improving rapidly. No pain, swelling nor stiffness. Given 30 mgm. Solganal B in muscle.

August 1, 1947: No complaints, 40 mgm. Solganal B in muscle.

August 11, 1947: Feels fine. No stiffness on arising in mornings now. 25 mgm. Solganal B in muscle.

August 19, 1947: No complaints, 25 mgm. Solganal B in muscle.

August 27, 1947: Had one short attack of pain in left shoulder at night. Given 40 mgm. Solganal B in muscle.

September 8, 1947: No complaints, 40 mgm. Solganal B in muscle.

September 22, 1947: Doing well. No joint complaints. Bowled today without discomfort. Given 40 mgm. Solganal B.

October 6, 1947: Feels perfectly well, 40 mgm. Solganal B.

October 25, 1947: No pain, stiffness, nor swelling of joints. Appetite is good. Once a week, he bowls three games without pain or discomfort. Given 30 mgm. Solganal B.

Total amount of Solganal B to date—440 mgm.

COMMENTS

It is my plan to continue gold injections every four to five weeks, for one year and then gradually discontinue therapy. The mechanism of action of gold in this condition is not known. However, the fact that it has been the only medication which gave relief to this patient, is of great importance.

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Coronary Artery Disease

As in the cases of coronary artery disease in which thrombotic occlusion has not occurred, the patients who have acute myocardial infarction are candidates for sudden death from profound disturbances of rhythm, such as ventricular fibrillation, ventricular tachycardia, and asystole. It has been suggested that under these circumstances foci of increased irritability arise in the junctional zone of myocardium between the infarct and normal cardiac muscle. However, likewise in these cases, the incidence of profound disturbances of rhythm is not known, because rarely does the element of time permit graphic registration of the activity of the heart. Where extensive infarction of the interventricular septum occurs, complete heart block with or without convulsive syncope may occur soon after the occlusion and eventuate in death in a few hours or days.—Frederick A. Willius, M.D., Rochester, Minnesota, Minnesota Medicine, Volume 31, Number 5, May, 1948.

Complete Transposition of the Great Cardiac Vessels

EDWARD W. MISKALL, M. D., and JOHN A. FRASER, M. D.

THIS case typifies one of those cyanotic congenital cardiac defects for which, according to Blalock and Taussig,¹ surgical treatment is of no value.

In this grave anomaly, there is an altered relationship of the great vessels to each other and to their respective ventricles, in such a manner that the aorta arises from the right ventricle and the pulmonary artery from the left ventricle. The blood is pumped from the left ventricle through the pulmonary artery to the lungs, and it returns to the left auricle through the pulmonary veins. Through the aorta the blood is pumped by the right ventricle to the greater systemic circuit. It returns to the right side of the heart through the venae cavae. In the absence of a septal defect, this condition is incompatible with life since no oxygenated blood can go from the pulmonary to the systemic circulation.

REPORT OF CASE

B. J. B., a white female infant, weighing 3.3 Kg. was delivered at full term February 4, 1945, after a normal gestation. The eighth thoracic vertebra was bifid, and through it a meningocele protruded. The latter was removed on the fifth day and the wound healed promptly. Cyanosis, first noted after a fortnight, gradually became more severe and persistent. In the sixth month, clubbing appeared. Growth and development were fairly normal. No murmurs were heard. Pneumonia caused death in the eleventh month.

In addition to pneumonia of the left lower lobe, the essential pathologic changes were in the heart. The heart weighed 61 gm. (The normal heart weight at one year is from 30 to 40 gm.) A small left auricle received the pulmonary veins. The superior and inferior venae cavae emptied into a normal sized right auricle. Immediately anterior to the orifice of the inferior vena cava, a small coronary sinus opened into the right auricle. There was a vertically elliptical interauricular septal defect, which measured 5 by 10 mm. Its margin was smooth and rounded. Just anterior to this atrial septal defect was a slightly larger oval opening. Through this latter orifice, the cavity of the right auricle communicated with that of its appendage which was located on the left side of the heart, anterior to, and in contact with, the left auricular appendage (Figure 1). The tricuspid valve appeared normal. The right ventricular wall averaged 7 mm. in thickness. The aorta, with a circumference of 30 mm., drained the right ventricle. It was placed directly in front of the pulmonary artery (Figure 2).

The aortic valve consisted of three normal cusps, one anteriorly placed, and a left and right posteriorly placed. From behind each of the latter two, arose a patent coronary artery. The distribution of the coronary arteries was

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normal, with the exception that the circumflex branch of the left artery was extremely small. The relationship that the coronary arteries bore to the pulmonary artery was a mirror image of the normal. A similar arrangement was observed in a case of cor biloculare we² described recently. The left ventricular wall averaged 4 mm. in thickness. Development of the two papillary muscles was fairly good, but that of the mitral leaflets was poor. The left ventricle was drained solely by the pulmonary artery (Figure 1); the circumference of which at the level of the pulmonary valve ring was 22 mm. The pulmonary valve cusps were normal. Immediately distal to the level of the valve ring, the pulmonary artery expanded to a circumference of 50 mm. and divided into left and right branches. At the bifurcation arose a fibrous non-patent ductus arteriosus 10 mm. long and 2 to 3 mm. in diameter (Figure 1). The ventricular septum was intact.

COMMENT

Complete transposition of the arterial vessels is a rare anomaly. Abbott's³ series of 1,000 cases of congenital cardiac disease included 74 cases, in 49 of which it was the primary defect. Seventeen of the 49 had ventricular septal defects, and 44 had auricular septal defects. Life was short for most of them. The greatest age attained was 16 years. The average was 6 months for those with intact ventricular septums, and 33 months for those with ventricular septal defects.

The origin of this anomaly has been extensively studied. Harris and Farber⁴ have minutely examined several theories including the phylogenetic one of Spitzer. Lev and Saphir⁵ believe that transposition results from an abnormality in the absorption of the bulbus. This, in turn, is due to an abnormality of a particular bulbar ridge.

Upon the right ventricle falls the burden of maintaining the arterial circulation in this lesion.

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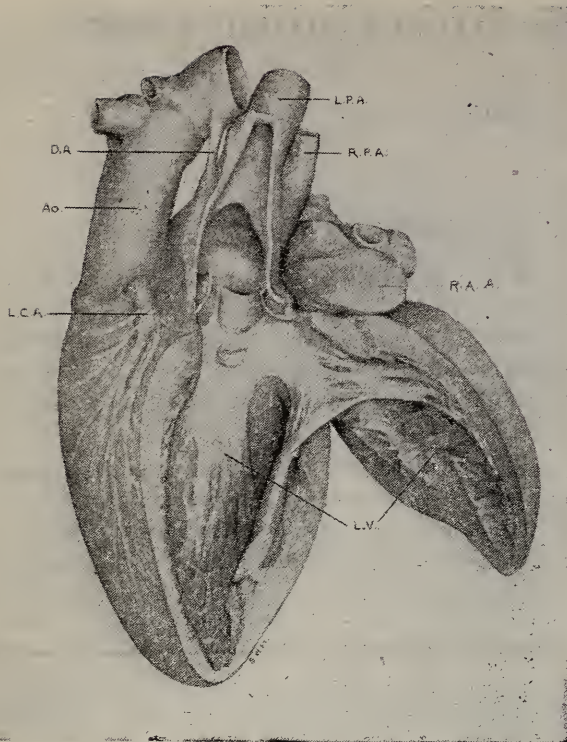


Figure 1—Appearance of the heart opened from the left. Ao., aorta; D.A., ductus arteriosus; L.C.A., left coronary artery; L.P.A., left pulmonary artery; L.V., left ventricle; R.A.A., right auricular appendage; R.P.A., right pulmonary artery.

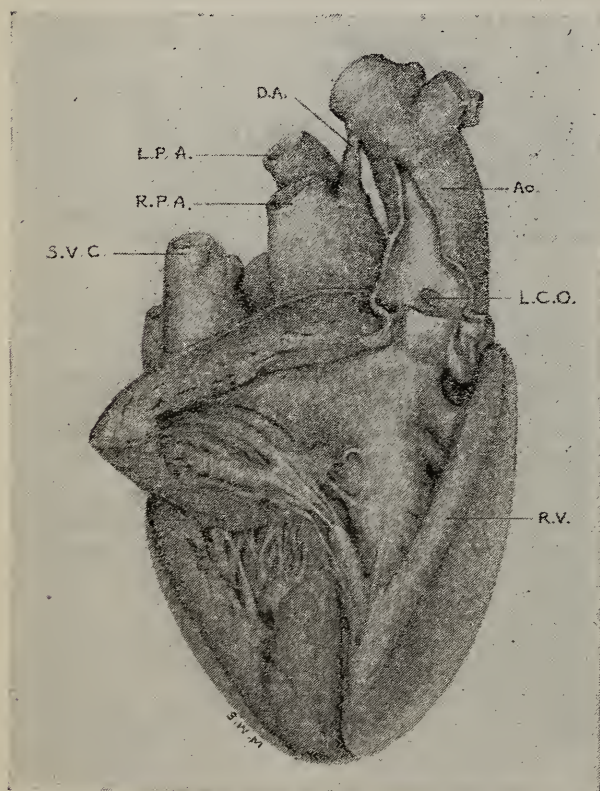


Figure 2—Appearance of the heart opened from the right. Ao., aorta; D.A., ductus arteriosus; L.C.O., left coronary ostium; L.P.A., left pulmonary artery; R.P.A., right pulmonary artery; R.V., right ventricle; S.V.C., superior vena cava.

Hypertrophy of this chamber is reflected in the right axis deviation of the electrocardiogram. Cyanosis is usually severe and persistent; but with large septal defects it may be mild to moderate. In the case reported, an interauricular septal defect provided for some of the oxygenated blood reaching the systemic circulation.

Diagnosis is difficult, but Taussig⁶ has described pathognomonic roentgenographic characteristics, namely, a narrow aortic shadow in the antero-posterior view and an increase in the width of the shadow cast by the great vessels in the left anterior oblique position.

This lesion is not amenable to treatment by the surgical anastomosis of Blalock and Taussig,¹ or by the recent modification of their operation as described by Potts, Smith and Gibson.⁷ These surgical procedures are effective only in those anomalies in which there is a lack of circulation to the lungs, chiefly the tetralogy of Fallot and pulmonary atresia. In complete transposition, as in the case reported herewith, the difficulty consists of the absence of adequate provision for the oxygenated blood to reach the systemic circulation. The other defects with cyanosis which obviously are not surgically remediable and which should be differentiated from the more common tetralogy of Fallot are aortic atresia, the Eisenmenger complex, tricuspid atresia and cor biloculare.

Alexander and White⁸ recently published an excellent discussion of the differential diagnosis of four types of congenital malformations of the heart accompanied by cyanosis.

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We know that the average death rate from tuberculosis is much greater in large cities than in the rural areas of the nation. Therefore, if we plan to eradicate this disease, there will have to be a concentrated, comprehensive, community-wide attack on the great remaining reservoirs of tubercle bacilli—our larger cities.—Cedric Northrop, M. D., *Nat. Tuberc. A. Tr.*, 1947.

Cosmetic Plastic Surgery—It's Relationship to Personality

J. GORDON HIMMEL, M. D.

WITH the rapid advance of reconstructive plastic surgery during the past decade, in technic, in availability to the public, and in the types of disfigurement that have been treated, new interest has developed in this field. Also, during the last decade or two, another closely related branch of plastic surgery, namely, Cosmetic Plastic Surgery, has advanced. Cosmetic plastic surgery, till recently, was relegated to the category of Charlatanism, Quackery, and "Beauty Parlor" Procedures. Most surgeons did not deign to waste their time learning the techniques or even practising that form of surgery, since it was considered highly elective and not important to life or health; rather, the plaything of surgeons catering to foolish people. However, just as psychiatry has risen in the estimation of the Medical Profession from a very low level to the high scale which it holds, so has cosmetic plastic surgery also risen in the minds of the Medical Profession; so that in selected cases, it is a necessary part of therapy. All psychiatrists will agree that the removal of a hump from a deformed nose, or removal of a facial scar, or even a "face lift" will do more to cure certain mental quirks or inferiority feelings than any medication or treatment.

The experience of surgeons has been, however, that the benefit derived is not always in keeping with the results. They have found patients who have benefited in both body and mind; but, also patients, who, although they have experienced very creditable surgical results, have remained dissatisfied and have shown that they are sick and maladjusted persons.

The remarks of Blair and Brown, famous plastic surgeons, of this country, even in 1931, were pertinent: "In rebuilding or in changing a nose, the surgeon is dealing with material facts related to anatomy and physiology, and with fundamental rules that have been formulated in regard to the proper ensemble of the facial elements; but, in passing upon the advisability of the attempt, he also must take cognizance of the patient's mental attitude. If that has become a bit warped, it can in the end, defeat the main objective, i.e., pleasing the patient, regardless of the fact that the newly made nose might be surgically and artistically as near perfection as the available material and skill permit.

PSYCHOLOGY IMPORTANT

"The psychology of patients who seek facial corrections should, therefore, be considered. As

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a general rule, the more pronounced the deformity or loss, the more likely is a reasonable good result to be acceptable; but, conversely, it is well to be cautious about embarking upon the correction of slight defects. Adolescents of both sexes, especially those who have no regular employment, are more apt to be over particular than are those who are more mature. Also, a patient's inability to state accurately and succinctly, the particular thing that displeases him, should excite grave self-doubt in the surgeon's own ability to satisfy. The same uncertainty should also excite the suspicion that the accused nose might not be the real fault."

The observations and views as listed in the rest of the article were made by the author while he was associated with a busy surgeon in Chicago who did only cosmetic plastic surgery, and the patients were observed in both the hospital and the office.

CLASSIFICATION

Barker and Smith, in their series, divided all cases with facial disfigurements into three main groups:

Group I, Superior—well adjusted class.

Group II, Persons with recessive or inadequate personalities who have retreated behind the "handicap" and unconsciously use it as a defense.

Group III, Persons with a pre-psychotic or psychotic personality—with whom the facial abnormality is the material for a schizophrenic process.

Group I—One finds moderately successful, well-adjusted persons, who have marked and

obvious disfigurements and who wish surgery performed for purely cosmetic reasons or for comfort, and not as an answer to all their problems—financial, emotional, and social. They do not expect too much of their improvement and have a logical concept of the outcome. They offer ideal material for obtaining successful results—both cosmetic and emotional.

Among this group were some men, who were successful in business. They appeared emotionally and financially stable, but, they had abnormal noses—either marked “hump noses,” or noses that had drooping tips or were twisted laterally. These men believed that an improved appearance in meeting the public would increase their chances for greater success and they thought that they should be as zealous of their “good appearance” as any movie actor. Many middle-aged women, many of whom were engaged in operating beauty parlors, including one well-known male hair dresser, came in for “face lifts,” because they thought that it was necessary that they keep a youthful and pleasant appearance in their type of business.

Many level-headed high school and college students, both male and female, came in for the removal of disfiguring humps on their noses because they thought that it would increase their future social and business prestige. I recall one case in particular, in which the young lady, just before the start of the operation, asked us to do a good job—because it meant the getting of a husband in the future.

These were all people who were level headed and well adjusted; and also had obvious defects which needed repair.

Group II—The recessive or inadequate personality group is composed of those patients who, feeling a marked handicap because of their condition, have secluded themselves and altered all their desires, emotions, and activities because of their facial appearance. They have become limited in their social scope, general knowledge, and social experience. They tend to develop a jealous, hateful personality, indicated by sarcasm, a cynical attitude, marked aggressive hates or loves, and active hate and envy, repressed for “normal people.” The ultimate result may be expressed as marked anti-social activity or sadistic desires. Their emotional development remains at an egocentric, immature, and childish level, making them selfish and thoughtless of others. The result of this immaturity is often laid at the door of the facial disfigurement by the patient. For years, the scar, harelip, or misshapen nose has been looked upon as a handicap; and it is the “crutch” on which the patient has hung all inadequacies, all dissatisfactions, all procrastinations and all unpleasant duties of social life. He has come to depend on it, not only as a

reasonable escape from competition, but, as a protection from social responsibility.

When one removes this “crutch” by surgery, the patient is cast adrift from the emotional protection offered by the “crutch” and in many cases, is unprepared to cope with the new situation; he may turn to the similar protection of neurasthenia, hysterical conversion, hypochondriasis, or the acute anxiety states.

INDICATIONS

There is great difficulty in deciding which of the patients in this group should and should not have surgery, so that some plastic surgeons make all or the great number of prospective cases have a conference with a psychiatrist; and they will not perform any surgery until the case has been passed by him as suitable.

This does not mean that all persons with inadequate personalities fall into a psychopathologic state and become problems after surgery. This is not true; because many lose their “crutch” and have a marked change and adjustment to normal. Those patients are everlastingly thankful.

Included below are sketchy cases; each of which could apply to many similar patients.

CASE REPORTS

Case I.—A white female, about 36 years of age, with a hump nose and a receding upper lip. The patient was short and not particularly shapely. Her hair and cosmetic makeup showed no real care or interest. Her clothes were dowdy and showed lack of interest. The patient has little or no social life of the kind she wanted. She had no dates and had never been inside of a night club; or had any “boy friends.” Because she had no social life and dates, she would be ashamed to stay home every evening. She was enrolled for educational courses every evening in either a night university or in the art museum, although she had not great interest in any of the subjects. She was hospitalized and the hump was removed. Then, the bony hump was inserted in a pocket in the upper lip to bring out the upper lip. After all the tissues had healed and sutures were removed, she was sent to a beauty parlor with instructions to learn how to wear her hair and apply lipstick to the greatest advantage of her particular type of new features. After she was instructed at the beauty parlor, she went on a shopping spree of her own accord. To fit her personality and with her loss of inferiority feeling, she bought daring hats and colorful dresses. When she came into the office for her final pictures and check-up, she was totally different. She was no longer a shrinking and dowdy person; she wore beautiful clothes and hats; her hair-do was different and she showed a pride in her appearance. She had already quit her night courses at the university and had made new social contacts, and was going to night clubs and social affairs. This case is just one of many of the same type who had made a good adjustment. With a case of this type, one is proud to have performed cosmetic plastic surgery.

Case II.—A white female, about 28 years old, an artist, had a large hump nose, and an appearance of carelessness about her cosmetics,

hair-do and clothes. Her social life was also quite limited. She had her nose repaired and also was given subsequent instructions about going to a reputable beauty parlor to receive instructions in how to fix her hair and cosmetics to her best advantage. When she returned about eight months later, she had a slight adhesion of the skin over one of the lower lateral cartilages. While being interviewed, she was very enthusiastic in describing how her whole life and personality had changed since the operation. She had, since the operation, acquired a husband and she was happy in her home and professional life. She was given a little narcosis, just enough so that the adhesion could be freed. Under the narcotic influence, she talked freely about how wonderful the surgeon was—who had freed her from an inferiority feeling . . . that had been ruining her life.

Case III—This was a white male, about 23 years old. The extent of his original nasal defect was not known, because he had had rhinoplasties and revisions by several good plastic surgeons. He came to us complaining about some defect which was so minute that it almost had to be imagined to be seen. It was immediately seen that this man had an inadequate personality and was using this as a "crutch," and that no operation would ever completely satisfy him. We would just become another on his list of plastic surgeons, who had or would operate on him. Surgery was refused.

Group III—The third group is composed of those persons who have a primary or basic personality inadequacy. They are unable to assimilate and digest the demands and restrictions of their environment, or to measure up to their opportunities and in casting about for a plausible basis for rationalization, come by chance, on a minor defect—such as a long nose or a scar. From this, they build up an all-inclusive rationalization of their difficulties, out of all proportion to the real values of the deformity.

Any plastic or reconstructive procedure only serves to interrupt the rationalization process and soon the resulting scar or some other trivial defect is seized on for continuation of the delusional construction which is often frankly schizoid. When such patients appear for surgical aid, the surgeon is wise to proceed with greatest caution, and it is suggested that physiologic function alone be used as the criterion for operative intervention. This criterion is offered because the emotional importance of the disfigurement is secondary to a basic, pre-psychotic personality and regardless of the technical success, the procedure will serve only to diversify instead of to remove the expression of an incipient psychosis. The operating surgeon should be very cautious, in the author's opinion, of even operating upon these people with a physiologic pathology, because these people have been known to inflict bodily harm or kill surgeons—weeks or months after surgery was performed, or start law suits.

Case IV—A 35-year-old white female, unmarried, came in requesting cosmetic repair of a nasal deformity. There was such imperceptible deformity that it was within the limits of a normal nose. It was decided to question her further, and she readily confessed that people on the street and on the buses, continually stared at her nose and she heard them talking about "how could a woman with such a deformed nose go about and not have plastic surgery done on it." It was decided that she had a paranoid type of schizophrenia and no surgery was recommended.

In addition to the above classifications of personality defects associated with cosmetic deformities, there is another minor classification which is not presented as having a scientific basis—but is one of those amusing compilations of statistics and facts which one can easily accumulate when dealing with different and many types of people. Since most of the patients seen in this type of practice were in Group I of the above classification, this minor classification can be considered as part of Group I.

AGE AS A FACTOR

It was found that most of the patients of Group I were normal women; but that they fell into age groups which were almost constant.

Group I—The girls in this group were either in high school or freshmen in college. They realized that they had deformed noses and that it would interfere with their social life; so they would raise a fuss at home to have it done. Many times the parents were reluctant or unwilling to consent . . . because to them, their children still looked good. Usually, the girls would come in, almost dragging their parents with them.

Group II—The girls in this group were in the last year in college or had just entered the business world. They knew that they had not had a successful social life during the last four or more years and they were slightly apprehensive about their future for marriage. They would come in alone, or with the ready consent of their parents.

Group III—Usually, these were unmarried girls about 35 or more years who had a very slight nasal or other cosmetic deformity and they came for cosmetic plastic surgery as their last resort in getting ahead socially or getting a husband. In this same age group, also, would be the married women, who would come in for repair of some deformity. Many times they would confess that they were losing their husbands and they were willing to have anything done to make themselves more attractive and desirable to their husbands.

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Hydatidiform Mole in a Twin Pregnancy With a Viable Foetus

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THE cases of co-existing, well-developed foetus and hydatidiform mole have been reported in the literature but they have not been numerous. These cases are mostly in the early months of pregnancy but when the foetus reaches term cases become fewer and even rare; as most abort in the first trimester and foetal parts cannot be found.

Bland¹ states that the existence of a well-developed foetus and an advanced mole in the uterus at the same time would seem physically impossible except in a plural pregnancy. Several other men have published cases of twin pregnancies with hydatidiform mole formation—Brews,⁴ Kangus,⁸ and Meyer,⁹ to mention some. One case of Bowles³ of Honolulu, Hawaii, reported a living child with a hydatidiform mole developing from a single ovum. Williams,¹³ in 1918, reported on 17,930 obstetrical cases treated at Johns Hopkins Medical School and that no case of viable foetus was found in conjunction with hydatidiform mole, although Meyer⁹ of Carnegie Institute of Embryology states that an embryo in a mole is not very rare. Small areas of mole formation can sometimes be found in normal pregnancy and delivery of a normal living child will result, though with extensive mole formation the cases are rare. Hirst⁷ states that if the disease does not begin until after the villi of the chorion laeve have atrophied, or if the degeneration is confined to a comparative limited area, the pregnancy usually proceeds to term or nonviability of the foetus. Titus,¹¹ Greenhill,⁶ and DeLee⁵ confirm this statement.

Hydatidiform mole is a cystic degeneration of the chorionic villi characterized by proliferation of the epithelial elements, obliteration of the terminal vessels and degeneration of the stroma with formation of cysts attached in clusters to the villus trunks. This change takes place in early pregnancy when the ovum is surrounded by chorionic villi and, except in rare instances, involves the periphery of the entire egg. Hydatidiform mole occurs about once in 3,000 pregnancies. Its etiology is not known but its origin is in the ovum itself because in twin pregnancies one becomes a hydatidiform mole while the other develops normally, as was brought out in our case.

In diagnosis of a hydatidiform mole the symptoms that present themselves are rapid

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enlargement of the uterus out of proportion to the period of gestation; bloody vaginal discharge; expulsion of grape-like cysts from the vagina. Nausea and vomiting are increased, and frequently a rise in blood pressure, albuminuria and other evidences of toxemia present themselves.

In review of the symptoms presented at the time of delivery of the above case report, albuminuria, edema of the dependent parts, vaginal bleeding, and uterus enlarged out of proportion to the period of gestation seemed to be the most universal factors common to all of the cases. These symptoms were present in our case as shown by the following case report.

CASE REPORT

This is the case of a 40-year-old, white female who was admitted to St. John's Hospital, Cleveland, Ohio, on July 7, 1947, because of vaginal bleeding. It was her seventh pregnancy and apparent at full term. It was hard to obtain an accurate history from the patient because of language difficulty. She had only made one visit for examination during this pregnancy and this shortly before her admission to the hospital. While in the hospital at this time she bled small amounts from the vagina and at no time was she uncomfortable nor was there any uterine contraction. Patient was sedated with seconal and demerol and strict bed rest. Bleeding subsided and patient was up and around on the third day. She was feeling well and was discharged. At no time during this visit was any mole formation passed vaginally.

Two weeks later the patient was again admitted to St. John's Hospital for the same reason—vaginal bleeding. History taken at this time was similar to previous admission—seventh pregnancy with uterus enlarged to one finger below the xiphisternal notch, apparently full term. Again the history of painless vaginal bleeding.

In 1944, patient had an abortion of a two-month foetus, cause undermined. The date of

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last menstruation was December 30, 1946. Patient had the usual childhood diseases including diphtheria. She denied any renal or cardiac diseases. Her first menses began at eleven and one-half years with frequency of every 28 days, lasting four to five days, moderate amount and little distress during menses. She has five children living and well and one dead which was the abortion mentioned above. During this pregnancy nausea and vomiting was present during the first trimester. The two-month period prior to admission she had edema of the extremities and two weeks prior to admission edema of the lower trunk. Otherwise the patient was comfortable during this period of gestation.

On admission physical examination revealed a 40-year-old white female lying comfortably in bed in no apparent distress. Temperature 98.6; pulse 88; respirations 20; blood pressure 144/80. Head and neck were not remarkable; thyroid was not enlarged. Heart was clear to auscultation and not enlarged to percussion, rate and rhythm were regular. The lungs were clear to auscultation and percussion, no rales were heard.

The abdomen was distended, which appeared to be full term pregnancy. The skin from the symphysis pubis to one finger above the umbilicus and extending over the whole lower abdomen showed moderate pitting edema. Upon palpation the fundus was one finger below the xiphisternal notch and foetal parts were not palpable. Foetal heart tone was good, 160 per minute heard in the midline, although at times it was difficult to hear. Several competent men examined patient for foetal heart tone but only one described the foetal heart tone. The ankles and legs were edematous. Patient was bleeding slightly vaginally. No uterine contractions could be felt nor was the patient in pain. Rectal examination at this time showed no dilatation nor could presenting parts be felt. This was at 2:00 a. m., on August 20, 1947. During the course of the early morning several large clots were passed but no mole formation was seen in any of them. Patient was given 500 cc. of plasma intravenously; blood pressure remained at 150/80. Four hours after the plasma had been given the blood pressure began to rise, reaching a high of 200/100. Patient was started on 2 cc. of 50 per cent magnesium sulphate intramuscularly. Blood pressure gradually subsided to 150/80. Catheterized specimen at this time showed a trace of albumin with a few granular and hyaline casts; many clumped white cells and a few red blood cells per high-power field.

The next morning the patient was supported with 1000 cc. of 5 per cent glucose in distilled water and 25 per cent magnesium sulphate intramuscularly. At this time consultation was called and a diagnosis was made of dead foetus, toxemia, partial separation of placenta. Treatment advised was induction of labor.

Patient was taken to the delivery room for vaginal examination and, if possible, to rupture membranes for induction of labor. Upon vaginal examination no presenting parts could be felt and copious bleeding resulted. It was decided not to rupture the membranes at this time. An additional diagnosis was made of placenta praevia. Patient was immediately taken to surgery for a Caesarean section because it was at this time that one of the examiners heard and described a foetal heart tone of 160 per minute in midline of lower abdomen.

Patient was prepared in the usual manner for Caesarean section and upon opening the uterus

in a classical section type of operation a large hydatidiform mole presented itself, completely filling the incision. The mole was promptly evacuated and during the process of evacuation a small foetus was felt and delivered. It began to cry immediately. It was taken to the nursery and placed in an incubator under continuous oxygen therapy. Following delivery of the baby a separate well-formed, normal placenta and membrane was removed from the lower part of the uterus. The abdomen and the uterus were thoroughly examined for any remaining pieces of the mole but none were found. The uterus and abdomen were then closed. Patient remained in good condition throughout the operation and was returned to her room. She had an uneventful postoperative recovery with discharge on the tenth postoperative day in good condition. The baby lived approximately 24 hours. Autopsy on the baby showed a normal infant approximately 6½ months old, weight 2 pounds, 4 ounces.

The pathological report of the specimen sent to the laboratory was as follows:

Gross Description: Specimen consists of a placenta with cord attached. The cord is attached eccentrically and measures 17 x 1 cm. The membranes are present and show no gross abnormalities. The second portion of the specimen consists of numerous gray opaque cysts filled with opaque material. The cysts vary in size and measure from 2 mm. to 3 cm. This mass has a grape-like cluster appearance. The material is very friable. The whole mass fills a quart jar. No foetal parts are seen.

Microscopical Description: Sections made through the placenta attached to the living baby reveal the placental villi to be average in size and shape. Their stroma is fairly vascular and show no abnormalities. Sections made through the mole reveal the characteristic enlargement of the villi with degeneration of the stromal tissue. The stroma is very avascular. Examination of the Langhan's layer and syncytial layer reveal some evidence of trophoblastic proliferation. It is not marked, however, and there is no evidence of malignant transformation.

Pathological Diagnosis: 1. Benign hydatidiform mole. 2. Placenta normal—no pathological diagnosis.

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Psychiatric Units in General Hospitals

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A great contribution which World War II made to modern medical care was to demonstrate to millions of people in the service the value of providing space in each hospital for the care of the mentally ill. In this way early cases received prompt care in specially constructed units at the hands of specialists, thus greatly enhancing the chances for a permanent recovery.

Such type of service is, of course, not new in medicine. Credit is given to Dr. J. M. Mosher (who was born in Albany, N. Y., in 1864) for establishing the first psychiatric unit in a general hospital in this country. This was the famous "Pavilion F" which was installed in the Albany (N. Y.) Hospital in 1901. He recognized that the mentally ill required special care and treatment and that the general hospital offered many diagnostic, consultant, and treatment facilities so essential to the total welfare of mental patients. At the present time in this 600-bed hospital, 42 beds occupy two floors for the care of mental patients. The director of the hospital states that "we are enthusiastic about having a psychiatric division in conjunction with our general hospital."

MANY UNITS IN OPERATION

The Michael Reese Hospital in Chicago provides 18 psychiatric beds in a 595-bed hospital and the director claims that "they are important and practical."²

The Highland Clinic in Shreveport, La., operates a 100-bed hospital, with 7 beds in one wing of the second floor devoted to mental patients. The director, Dr. D. H. Duncan, stated that "the psychiatric service is of practical importance to the operation of the hospital generally."²

The Henry Ford Hospital of Detroit has 572 beds, 50 for psychiatric patients. This unit has been in operation for 20 years rendering great service to the hospital and community.²

St. Mary's Hospital in Duluth, Minn., has 10 psychiatric beds in a 300-bed hospital. Sister M. Patricia, the administrator, stated that, "due to the increased demand for this type of service, at least 25 to 30 beds should be available."²

The Methodist Hospital of Omaha, Neb., provides 14 psychiatric beds in a 174-bed hospital. The superintendent of this institution said that "this department has been a valuable asset to the hospital."²

Mercy Hospital, Canton, Ohio, has about 260 beds with a 12-bed psychiatric pavilion which has been in operation since 1929; a further expansion is planned.³

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By providing such facilities in all of our hospitals, early diagnosis and treatment of mental disorders would be insured and the heavy burden borne by the community in the way of state hospitals would be greatly lightened. Mental illness, just like cancer and diabetes, must be treated early and effectively to obtain results. Under our present facilities, proper care can only be provided in a few scattered, crowded sanitariums and in state institutions with the result that treatment is all too frequently postponed until irreparable damage has been done.

Unlike cancer, which kills its victims within a matter of months, mentally ill patients may become public charges in institutions for as much as forty or fifty years. With our present inadequate facilities, patients must be hospitalized some distances from their homes and practically always lose contact with their family physicians, many of whom brought them into the world and ministered to their needs throughout their lives.

In the past, one of the greatest obstacles to the handling of mental patients in a general hospital was the noise created by excited, disturbed patients. With modern methods of shock therapy, it is no longer necessary for a patient to be severely disturbed for weeks at a time—with a few treatments, conduct and behavior are readily returned to a state approaching normalcy; improvement then continues so that many patients are ready to return home within a month after admission. In order to further provide for the occasional "noisy" patient, the McMillen Hospital of St. Louis has complete automatic air-conditioning (heating, cooling, and ventilation) so that windows need never be opened.⁴ This, with soundproofing throughout, absolutely prevents any disturbance on the psychiatric floor from filtering to other parts of the hospital. In fact, there is actually less noise than is usually heard emanating from the labor rooms or from a nursery full of newborn babies.

It is of great importance that all the modern

facilities of a hospital be available to meet the physical needs of mental patients so that those with heart trouble, lung conditions, stomach disorders, etc., and those requiring operations (particularly in case of emergency) will be in a position to obtain these services.

EMERGENCY SERVICE

From time to time on the general medical, obstetrical, or surgical wards, a patient may suddenly show mental symptoms. Frequently these are the result of delirium due to fevers, toxins, or even a sensitivity to certain medicines. The majority of these conditions are temporary, but during such periods the patient must frequently be tied in bed and watched over night and day by special nurses. Even under such supervision, a patient may leave the hospital room through a window, resulting in serious injury or even death. Special units would provide proper safeguards for such patients without removing them from the hospital out of the hands of their own personal physician. Cases of attempted suicide are usually rushed to the emergency rooms of the neighborhood hospitals; proper facilities for their further treatment and observation are never available unless the hospital is advanced enough to have a psychiatric unit.

In the care of the mentally ill the need for properly trained, sympathetic personnel of the highest calibre is of utmost importance. These patients must be guided, directed, and encouraged throughout their illness by understanding nurses and attendants. Such personnel would be an integral part of the general hospital staff subject to the same constant, close supervision so that a high standard of care in the unit would be maintained. Furthermore, the presence of the family doctor, working in conjunction with the consulting psychiatrist, would be an additional factor in bringing out the highest type of service in the management of these patients.

One of the responsibilities of a hospital is to train young doctors and nurses for their place in safeguarding the health of the community—the intern of today is the family doctor and specialist of tomorrow. Such facilities would provide excellent opportunities for working with mental patients and would train the physician to be of much better service in practice whenever he encountered such cases. The number of practicing psychiatrists in Cleveland, Ohio, has doubled since the war and a majority of the freshman class at the Western Reserve Medical School (to be graduated in 1950), has indicated a desire to enter the field of psychiatry. Places for these men to practice their specialty must be provided if they are to do their best work. The educational value of a unit has been amply discussed by Harris and Ford.⁵

At the 48th Annual Convention of the American Hospital Association held in Philadelphia in September, 1946, the report of a two years' study by a 22-member commission on hospital care was made public. With regard to the field of mental health, the report said, "Many individuals in need of medical assistance of a psychiatric nature do not now receive it because of the stigma attached to being committed to an insane asylum. A far greater percentage of the population would receive adequate mental therapy if it were more readily available in general hospitals.⁶ A very detailed, comprehensive table of organization for a psychiatric service, which can be adapted to the needs of any hospital, has been devised by Dr. L. S. Kubie.⁷

Although the cost of construction and operation of psychiatric units will add to the initial outlay in building costs, the saving to the community in the long run will be inestimable. Homes now disrupted by mental disorders will be kept intact and children growing up in such homes will be provided with the proper guidance and leadership which will enable them to take their places as contributors to, rather than dependents of society. Dr. A. E. Bennett of Omaha, Neb., a pioneer in this field, has shown that costs are well within the reach of every hospital and that such units can even be self-supporting.⁸

SUMMARY

1. Provide modern facilities for early diagnosis and treatment of all types of mental disorders (originating inside or outside hospital).
2. Enable the patient to remain in his own community in touch with his family physician.
3. Provide training facilities for interns and nurses.
4. Bring the psychiatrist in closer contact with his medical colleagues, to their mutual benefit.

CONCLUSION*

Throughout the country hospitals are developing their post-war building programs. It is the present-day responsibility of the psychiatrist to assume leadership in establishing proper psychiatric care in his community.

* Since this paper was presented, a 14-bed unit has been opened at Lakeside Hospital, University Hospitals of Cleveland, under the Department of Psychiatry, Western Reserve University Medical School. This represents the first of such units to be opened in Cleveland.

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Myxedema Heart with Cardiac Failure

ROBERT H. SCHOENE, M. D., and A. L. POLLOCK, M. D.

BECAUSE of its relative infrequency, a classical case of myxedema heart with congestive failure is herewith presented. Cardiac enlargement with hypothyroidism which responds to thyroid medication is not uncommon. Zondek in 1918 described this syndrome as "myxedema heart." It was he who noted the enlargement of the heart, the sluggish heart action reflected in the low pulse pressure and the electrocardiographic changes. However, most investigators agree that congestive failure with myxedema heart is rarely seen.^{1, 2, 3} This is thought to be due to the fact that in myxedema the lowered metabolism decreases the demands of the body tissues for oxygenated blood and permits the heart muscle even though it has undergone pathological change, to decrease its output to a level which it can readily maintain.¹ The pathology has been well described by LaDue³ who presented the autopsy findings in a patient dying of heart failure due to myxedema. "Sections of the heart muscles just beneath the endocardium showed striking changes. In many places the sarcoplasm of the myofibrillae was completely replaced by hydropic vacuoles. Elsewhere there was branching and loss of striations of the individual fibers. Some of the cells were pale, others were deeply stained, small and had pyknotic nuclei. Stains of the vacuoles were negative for fat, mucus, and glycogen, indicating a true hydropic swelling similar to that noted in the edematous patients with myxedema. These changes were present but much less pronounced in other sections of the myocardium."

The pathological physiologic of myxedema is widespread and affects many other end organs among which are the gonads.³ This leads to sterility in both sexes and various menstrual disorders in the female. The breasts undergo fatty degeneration, and the effects on the skin, hair, nails, subcutaneous tissues, and teeth are well known. The intolerance of the organism as a whole to cold is also a reflection of the lowered metabolism.

The clinical course and laboratory findings in myxedema are too well known to warrant detailed discussion. The onset is as a rule gradual. There is a slowing of the mental processes and body activity, an increase in weight, decrease in appetite and the development of a peculiar dead-fish, mask-like facies. The features become coarse, the eyelids scant, and the hair coarse and dry. A few of these

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people are nervous and irritable, but for the most part they are quite pleasant. The heart is enlarged, the pulse slow, and the pulse pressure is decreased. The joints and muscles are frequently stiff and painful. There may be albumin in the urine and the phenolsulfonphthalein test may be low. The blood cholesterol is high. When thyroid secretion is entirely absent the basal metabolism falls to about 40 per cent below normal. In the electrocardiogram the most common finding is a flattening or an inversion of the T wave.^{5, 6, 4} The P and QRS complexes are very low in amplitude, and there may be left axis deviation. Cardio-fluoroscopy reveals an enlarged heart which shows very slight pulsation. This will sometimes simulate a pericardial effusion or even an adhesive pericarditis. The decreased pulsations are in marked contrast to the exaggerated pulsations seen in the usual enlarged heart.

It must, of course, be realized that not all cases seen will present the above classical picture. One who sees a failing heart without a clear-cut cause such as hypertension or chronic valvular disease, for instance, had better keep the hypothyroid element in mind. The following is the case record and the clinical course of the patient that prompted this report.

CASE REPORT

Miss E. R., 37-year-old white female stenographer, was admitted to the hospital on August 3, 1946, with the complaints of swelling of the feet, ankles, hands, neck, face, eyes, and a choking sensation. These had been progressive over a three-year period. About three months

Submitted February 3, 1948.

before admission she began to suffer extreme exertional dyspnea, orthopnea, and inability to lie on her left side in bed. This was associated with a definite increase in the frequency and intensity of her choking spells. These last symptoms had become progressively worse until she was unable to go up and down stairs and carry on her usual daily occupation. Weakness and weight gain plus nocturia and frequency in association with the above train of subjective complaints were present. There was an associated anxiety and apprehension. She had a feeling of mental and physical torpor and was chilly all the time. There was a constant dull ache over the precordium and her face and eyes felt swollen and woody so that she could not smile or indulge in the usual facial grimaces.

Five years before admission she began to have irregular menses and in the past year had menstruated only twice at widely spaced intervals. She exhibited some hot flashes. Her weight five years ago was 97 lbs. and her stated weight on admission was 142 lbs. She further volunteered the information that the texture of her hair had changed and that it would no longer take a permanent, plus the fact that her nails had become so brittle that she could no longer get a satisfactory manicure. Her past history was negative for illness, injury or dis-

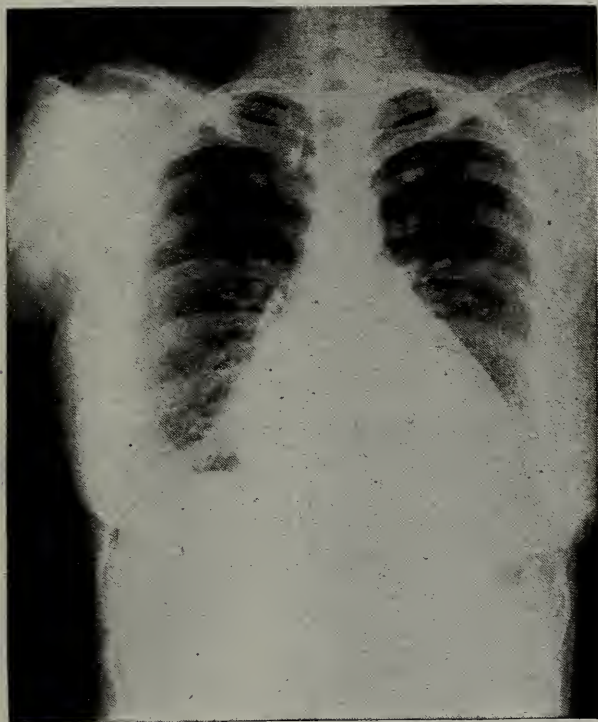


FIGURE 1.

ease. Her father died at aged 67 of cirrhosis of the liver. He had been a known lifelong hypothyroid.

On physical examination the temperature was 98, pulse 90, respiration 30. The entire facies presented a mask-like expression with thick, edematous eyelids, a broad, flat nose and a thick short neck with fatty supraclavicular pads. She had a loggy, sleepy look. The skin over the entire body was pudgy and had a doughy feel. The hair was scanty and on the head looked coarse with no lustre or sheen. The nails were brittle and furrowed. The thyroid gland was not palpable. The heart was enlarged in all diameters as will be noted in the X-ray (Figure 1). No precordial friction rub could be

heard and there were no organic murmurs or thrills present in the heart save for a soft, blowing systolic murmur at the apex. P_2 was accentuated. Moisture was present at both bases although no free pleural fluid could be made out. The abdomen contained no free fluid and the liver was just palpable not tender, and the normal sharp edge was present. Pitting edema of both lowers to the knees was present. The basal metabolic rate was minus 43 per cent and minus 44 per cent on repeat tests. The blood cholesterol

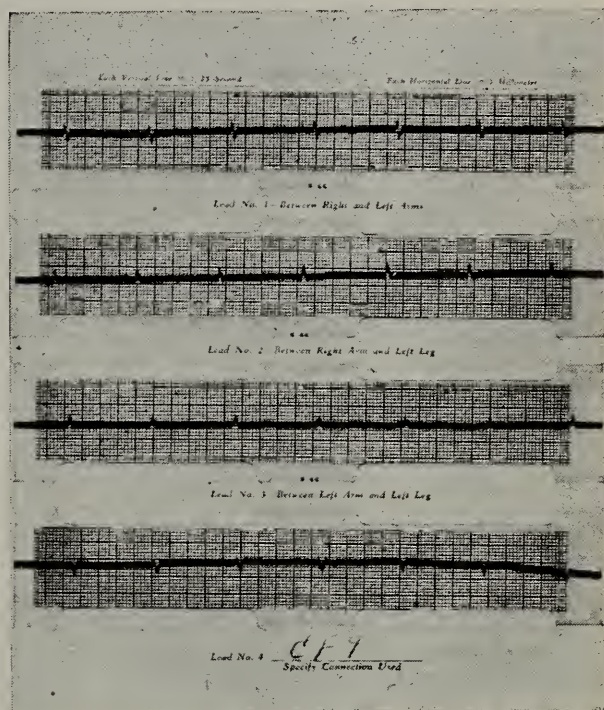


FIGURE 2.

was 280 mgms. per cent and the nonprotein nitrogen was 40 mgms. per cent. Red blood count 4,000,000 with 80 per cent hemoglobin. The white blood count and differential counts were within normal limits. Total serum proteins were 6.8 grams, with 4.5 grams albumin and 2.3 grams globulin. The dilution-concentration tests were impaired to a minor degree and the sedimentation rate was normal. Circulation time was 47 seconds from arm to tongue and the venous pressure values were 158 mm. of water. The urine showed a moderate amount of albumin and pus cells.

The electrocardiogram showed extremely low voltage of the QRS complexes throughout. There were associated flat to absent P and T waves throughout as shown in Figure 2. This tracing is rather typical of a hypothyroid heart.⁸ Cardiofluoroscopy and X-ray showed a transverse diameter of the heart of 15.5 cms. with the greatest internal diameter of the thorax being 24.5 cms. The entire cardio-pericardial silhouette was much greater than normal limits. Only faint pulsations of the ventricles could be detected and there was no calcium noted in the pericardium or heart shadow. The heart descended with the diaphragm on deep inspiration. The most important syndromes considered in a differential way were: Adhesive or Constrictive Pericarditis, Picks' Disease, Chronic Glomerulonephritis and an old missed Coronary Infarction with chronic decompensation. It was our feeling with the history obtained, the classical clinical picture, the laboratory findings includ-

ing cardio-fluoroscopy and electrocardiogram that the diagnosis of myxedema heart with decompensation was justified. Accordingly the patient was started on .25 mgms. Thyroxin together with 5 drops of Lugols solution daily. She tolerated this dosage nicely and in eight days the blood cholesterol had dropped to 161 mgms. per cent and the patient showed definite clinical improvement. The circulation time in ten days had dropped to 20 seconds (arm to tongue method) and at the same time the venous pressure was 135 mm. of water. She was discharged on the above routine on August 25, 1946, in a much improved condition to be followed on an ambulatory basis.

On September 1, 1946, the basal metabolic rate was minus 26 per cent and the electrocardiogram was beginning to show a small but definite T wave. At that time the Thyroxin was increased to 0.4 mgms. daily.

By October 17, the hair showed a normal texture together with healthy changes in the nails and skin. All signs of cardiac decompensation had disappeared. On October 29, the electrocardiogram showed an essentially normal tracing (Figure 3), which has maintained up to the present writing. Cardio-fluoroscopy and X-ray revealed a marked change in the cardiac silhouette (Figure 4) as compared to the original picture (Figure 1), the ratio now being within normal limits.

About this time she began to secrete a milky substance from both breasts and have a few lower pelvic cramps. The basal metabolic rate was minus 10 per cent and she had lost ten pounds in weight.

By April, 1947, she was tolerating 0.6 mgms. of Thyroxin daily. At no time was there any angina or precordial discomfort manifested on the dosage employed. On May 24, 1947, she had her first menstrual period for one year showing a return of normal ovarian function. The patient was back to her old position on a normal basis with full possession of her mental and physical faculties. Her maintenance dose of Thyroxin has at present been established at 0.6 mgms. daily.

DISCUSSION

There is no clear-cut reason to explain why some myxedema hearts undergo congestive failure. Certainly, as mentioned before,^{1, 2, 4} this is a rare syndrome. There may be many reasons from a pathological physiology standpoint why this is so. One can predicate perhaps that there may be some basic pathology other than the myxedema in those cases that go into congestive failure. In our case thus far we have been unable to show this to be true. Thus one must always distinguish between the "myxedema heart" and the myxedema heart with congestive failure.²

There have not been enough autopsy studies in either case to show whether the heart undergoes permanent pathological change. This would entail a long range study using every and all means available for cardio-vascular study on specific cases. Already some work done indicates a high incidence of coronary sclerosis in these hearts.⁴

Thyroid medication may cause rapid relief or aggravation of the decompensation together

with severe angina and cardiac discomfort. It has precipitated death in too many reported cases. It must be used with caution and if there is any hint of increasing decompensation or angina this should be a red flag to reduce or

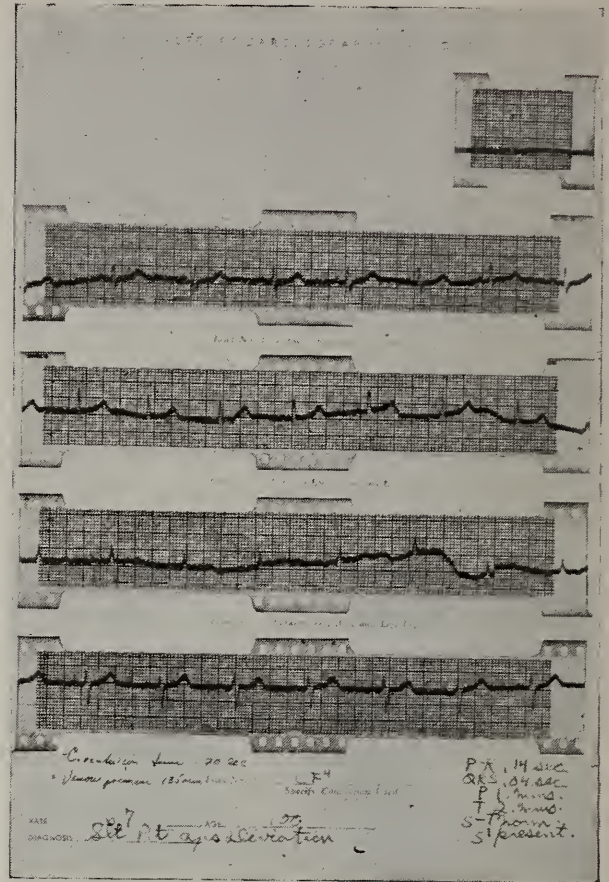


FIGURE 3.

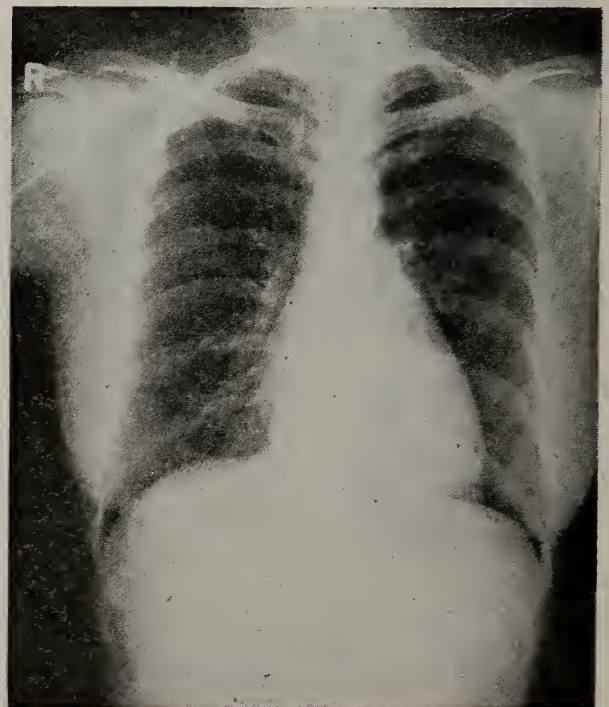


FIGURE 4.

discontinue all thyroid therapy. This dual potentiality of thyroid extract cannot be emphasized too strongly. To repeat, it is a rather specific, spectacular means of clearing the myxedema case with all its complications or else it may precipitate cardiac decompensation with cardiac infarction for many reasons that are quite obvious.

It is our feeling that there are more cases of congestive cardiac failure in myxedema than have been reported, and it has been our good fortune to see a second case in recent months in a 55-year-old white female which was proven by autopsy, the diagnosis being made ante mortem. Whenever congestive failure is present without obvious etiological reasons one must think of myxedema as the cause of the clinical condition present.

CONCLUSION

A classical case of a myxedema heart in congestive failure has been presented. A discussion of the altered pathological physiology involved together with the diagnosis and treatment has been considered.

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Treatment of Hyperthyroidism

Our experience with propyl thiouracil, to date, reveals that it is much less toxic than thiouracil. It had to be discontinued with one patient because of a febrile reaction. One patient had mild headaches which disappeared after a few days. This same patient also had peculiar pain in the jaws and muscles of the face. Two patients had mild gastric upsets. Practically all of the toxic manifestations of propyl thiouracil occurred within six weeks after the institution of therapy.

Most of the patients responded within ten to twenty-one days as manifested by the amelioration of the thyrotoxic symptoms. This delay is believed to be due to the time taken by the body to use up the preformed store of thyroxine. As with thiouracil, patients who had had previous iodine medication responded more slowly.—S. Rinkoff, M. D., and M. Spring, M. D., N. Y. C., N. Y. State Jr. of Med., Vol. 48, No. 9, May 1, 1948.

KEEPING UP WITH MEDICINE

• A RECENT study by Litman and Bosma indicates that, other things being equal, susceptibility to poliomyelitis in growing children is increased by conditions which lead to unsatisfactory growth and that factors associated with poor growth predispose to attacks of poliomyelitis.

* * *

• • INCREASING attention is being paid to improving the amenities of rural life but badly constructed unsanitary wells are everywhere. It is to be remembered that no well water should ever be used for infant feeding unless and until it has been tested for its nitrate content and no water with a nitrate content of over 10 parts per million should be used in an infant's formula. Methemoglobinemia is the probable diagnosis in all cases of cyanosis in infants under two months of age. The first thing to do is to take away the well water and have it analyzed for confirmation.

* * *

• THE TIME has come for a further division of labor in the field of medicine. Let the public health worker concentrate upon using the resources of science and of civil government upon the prevention of disease, let the medical practitioners provide the skills and humane considerations due the sick and the suffering. Then provision should be made for the teaching of everyone of our citizens the normal biology of living so that everyone will keep their health, and the work of both the public health worker and the physician will grow less and less.

* * *

• TO ME the most interesting problem about isotopes is the question of disposal of the waste. What is to be done with them when one is through with them?

* * *

• ONE ADVANTAGE of propyl thiouracil in comparison with surgery or radio-active iodine is that of reversibility.

* * *

• NO MERE extension of our present health services will ever meet the fundamental health needs of man and his family.

* * *

• SPECIALIZATION detracts from the interest of life and diminishes gaiety and gusto in living . . . but "a masterly inactivity" will not cure disease.

* * *

• PERSONS who wear falseteeth make up a large percentage of the tooth-pick swallowers who must undergo surgery.—J. F.

Fibroma of the Ovary with Ascites and Hydrothorax

PAUL M. SPURNEY, M.D.

THE association of ascites and hydrothorax with large fibromas of the ovary was defined by Meigs as a clinical syndrome in 1937, although evidence of this condition is found in the literature long before. Calmenson, et al., report nine cases after a review of 20,000 pelvic tumors at the Mayo Clinic; they estimate the rate of occurrence at .05 per cent of large pelvic tumors. Although fibromas of the ovary are the main cause of the syndrome, other ovarian or uterine tumors, including an occasional malignancy have been associated with hydrothorax and ascites which disappeared on operative removal of the growth. These cases are of interest not only because of the occurrence of the fluid, but also because of the possible error of diagnosis, particularly heart disease.

HISTORY OF A CASE

Miss M. M., aged 42, entered the hospital on April 21, 1947, complaining of shortness of breath with a feeling of abdominal fullness and enlargement of the waist line of one year's duration; six months later she noted a "lump" in the abdomen. In the last few weeks she became progressively short of breath, which was her main reason for consulting a physician. Examination revealed a short, obese woman, markedly dyspneic, with evidence of fluid in both thoracic cavities and abdominal ascites through which a large nodule was palpable giving an impression of floating in the fluid. Temperature was normal; pulse and respirations were both rapid. Shortly after admission 2500 cc. of a blood-tinged fluid was removed from the right chest to relieve the dyspnea; the next day 3500 cc. of an exactly similar fluid was removed from the abdominal cavity.

Laboratory reports showed both blood and urine normal. The blood urea nitrogen was 8 mg. per 100 cc. and the icteric index was 4 units; no protein estimation was done. The electrocardiogram report was abnormal; this was considered as possibly due to embarrassment of the heart by pressure. On the second day 2500 cc. of blood-tinged fluid was removed from the left chest; an X-ray of the chest taken shortly after this was reported as a bilateral plural effusion with an area in the right lower lobe of the lung suggestive of a metastatic lesion. Examination of the fluid showed the presence of large irregular cells which further raised the question of malignancy, but the pathologist finally determined they were atypical epithelial cells. A provisional diagnosis of Meigs syndrome was made in spite of the X-ray finding.

Preoperative preparation of the patient was difficult because of the rapid recurrence of the fluids, but on May 12, 1947, laparotomy revealed a large tumor of the right ovary; removal was not difficult and the patient returned to bed in good condition. Recovery was without incidence and the fluid gradually disappeared. Later, X-ray failed to reveal any evidence of the suspected metastatic nodule, and the patient is well at this

Submitted January 9, 1948.

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date. The pathological report showed a large fibroma of the ovary, weight 2040 grams, showing marked edema in the tissue and in the pedicle.

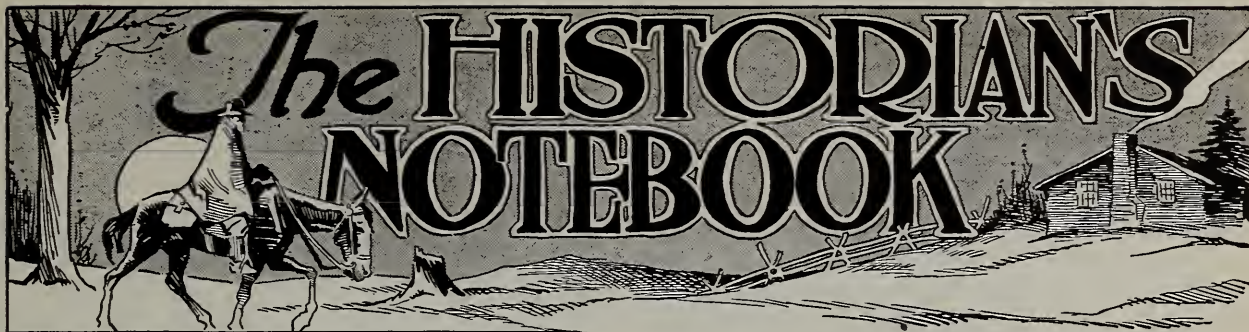
DISCUSSION

There is nothing unusual in the history or laboratory findings of this patient to differentiate it from other cases as reported in the literature, but it should be emphasized that the physician must be on the alert to recognize the syndrome, and not be led astray by the finding of a heart embarrassed by pressure, and an abnormal electrocardiogram. A slowly enlarging abdomen, with a sense of fullness, with very little pain, and a final severe dyspnea is not typical of heart disease. The surgeon, also, should not be confused by the finding of large irregular cells in the fluid which might be confused as tumor cells.

The cause of the ascites undoubtedly lies in the tumor itself, for pathologic studies show marked edema of the tumor and its pedicle, and the vessels supplying these growths are easily compressible, or subject to twists of the pedicle which might explain the blood-tinged fluid as found in this case. In the case of ovarian tumors whose surface is not covered by peritoneum but by a low cuboidal epithelium, it would be an easy matter for the fluid to permeate into the abdomen. The source of the hydrothorax is considered as a direct extension from abdomen through the lymph channels of the diaphragm.

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Ohio Medicine in the Gay Nineties

Part III—1890-1945

JONATHAN FORMAN, M. D.

(Concluded from June issue)

ALTHOUGH the first two American hospitals were established in 1751, still by 1826 the number had only increased to 17. It, however, was not until the second edition of the American Medical Directory in 1909 that there was reliable information available about practically all of the hospitals.

The phenomenal increase in hospital facilities since the early part of the present century cannot be explained in terms of population increase. While the population was increasing one and a half times from 1900 to 1940, in 1909, the hospital bed capacity was 421,065 and in 1943, it was 1,649,254. The development of surgery and the introduction of a whole battery of diagnostic gadgets as well as the tendency of physicians to practice in hospitals as a matter of convenience created the demand for an ever increasing number of hospital beds.

The centralization of our population in cities with an ever increasing number of childless couples being crowded into smaller and smaller apartments compelled most of our people to go to the hospital for care when they were sick. There was no one at home to care for them. In the last decade the Blue Cross Plan of prepayment of hospital bills has made it much easier to enjoy the advantages of hospital facilities. Experience has shown too that the single person, living alone, has to be taken to the hospital when sick with the simplest ailment. There is no other way. When one of a childless pair is sick, it is cheaper and better to go to the hospital than to lose all of the family income by the other member staying home to care for the sick one. But the more children there are in the family, the more likely are the sick to stay home.

So, whereas in 1890 the hospital was generally looked upon as a place to go to die, our inventions of machines, a well-planned selling job, and the economic pressure of modern urban life has brought about a great demand for hospitals which our economy has not been able to meet.

With the development of machinery, our hospitals have taken on more and more the appearance of factories. As they stand, however, the modern hospitals are the only factories in which mass production has increased rather than lessen the cost. Everywhere else the machine has reduced labor costs and the implication in all the current talk about building medical practices around hospitals implies that the same is true in the case of our hospitals. Such, however, is not the true case. There are many completely equipped offices of physicians where thorough examinations can be made for one-third to one-half the cost of similar studies in hospitals. What seems to be needed is some efficiency engineering.

I often wonder what would happen if the Austin engineers or other similar experts in factory design and machine location were called in to lay out our hospitals with the idea of making a factory for the treatment and care of the sick, instead of a memorial to the Architect or the Benefactor. I suspect that hospital building and operating cost could be cut in half.

As hospitals grew into the framework of Big Business, building costs mounted from a few hundred dollars a bed in 1890 to \$25,000 which the Veterans Administration was paying at the end of the Second World War. The day is not far distant when the efficiency engineers will have to overhaul all of our ideas about hospitals both in their construction and their management.

The total cost is now so out of line with our people's ability to pay—not only as individual citizens but also as communities and as a nation that sickness has become a luxury which we as a people can no longer afford.

For this reason if for no other we should soon be compelled to seek means of preventing sickness. Instead of trying to take better care of more sickness we shall be compelled to keep our health. This means more than a pure water supply, vaccinations, mass X-rays, preclinical examinations, and quarantine; it means teaching our people to live in a fashion that is normal biologically through proper food properly grown on fertile soil and properly prepared to be always resistant to disease and thus to do away with the need for hospitals entirely.

Professor R. N. Paddock

Professor R. N. Paddock is another of those live men, living in the memory, who constituted a part of the galaxy of worthy instructors of the College, and who seemed to know, or at least we thought he did, as much about the various component portions of the mechanism of the fearful and wonderful human fabric, as any other living man. His portly appearance, his black, heavy hair, his sharp, penetrating eyes, and his forcible address, never failed to make a favorable impression. One of his utterances especially I shall not soon forget, and it was not of an anatomical character, either. The reason doubtless is, that, in connection with its intrinsic worth, it was one of Prof. Paddock's peculiar expressions, and uttered to the class, that makes it more valuable than gold. He said on a certain occasion, I do not now remember what circumstance originated it: "Gentlemen, be exceedingly careful of your orthography, for if you should be so unfortunate, some time or another, to misspell *one* word, it may deprive you of an important position, or shut the door to higher promotion and coveted fame! I knew," said he, "some time ago, a certain aspiring young physician (which novitiates generally are) applied for a professorship in a medical college by writing to the trustees, and in that little missive he spelt one word incorrectly, and only one, but then that was enough to cause them to reject his application, and disappoint his hopes and prospects in that direction. How, his poor orthography did the mischief! Do not, any of you, gentlemen, go and do likewise."—*Reminiscences Bearing Upon the Faculty and Students of Starling Medical College During the Session of 1853-54.* J. S. Haldeman, M.D., Zanesville. Delivered March 9, 1888.

Professor Samuel M. Smith

Nor can I ever forget the name of Samuel M. Smith. It requires no bust nor statue of bronze to keep him before the mind's eye. And yet I believe you have one in this city. And may I be allowed the expression, it can never be as imperishable as his name! And the acts he performed! Samuel M. Smith does not only live in my memory because he was Professor of Theory and Practice in Starling Medical College, but also because he hailed from the classic halls of that grand old State institution, the Miami University. He went out from it, buoyant and aspiring for future laurels, about the time I entered it. He was a very positive man, but generally cautious and correct. And yet the idea, somehow or other, lingered in the mind of the student that he was not infallible. I remember very distinctly, as though uttered yesterday, when detailing with his accustomed minuteness the various remedies for phthisis pulmonalis, he said: "When you have come to the end of the long string of cures, and the betterment of the patient was not discernible, and the prognosis was irresistible that death would end the career by and by, as a last and desperate resort, advise him to go to some miasmatic locality, and if possible, contract the ague, and, if that does not cure him, nothing will!"

Another circumstance, relative to Prof. Smith, that lingers on the tablets of memory, and is fresh every morning and evening is, that he was necessitated, one time, to disappoint the class. We waited and waited, until the time had nearly expired, when neither he nor his manuscript made their appearance; for, be it known that he never, that I now remember, appeared before the class unaccompanied by his manuscript. Therefore he knew just what he was going to teach, and never floundered and got into the brush. When he appeared the next day, as a matter of course he made an apology, which was expected. And what do you think it was? It ran in this wise: "Gentlemen, by the exorbitant and unalterable decrees of obstetrics, I was tied to a bed post, and guarded by a band of females, who kept constant, anxious and sympathetic vigil, and could not be released until the hour for the lecture had passed." As in the case of Prof. Lee, so also with Smith, characteristics of this kind could be multiplied, but to enumerate them would make this production too prolix.—*Reminiscences Bearing Upon the Faculty and Students of Starling Medical College during the Session of 1853-54.* J. S. Haldeman, M.D., Zanesville, Ohio. Delivered March 9, 1888.

A.M.A. Officers' Reports . . .

Reviews Submitted for Annual Session Give Cross-Section Picture Of Activities Engaged in by National Officers, Committees, etc.

FOLLOWING are excerpts and briefs from reports of officers, councils, bureaus, committees, etc., of the American Medical Association submitted at the Annual Session in Chicago, as published in the May 8 issue of *The Journal of the A. M. A.*:

SECRETARY'S REPORT

On April 1, 1948, the official membership list of the American Medical Association contained the names of 136,668 physicians, an increase over the preceding year of 4,444. During the last ten years there was an increase in the number of physicians in the United States and its dependencies of 27,321. There was an increase in the membership of the A. M. A. of 27,233, only 88 less than the increase in number of physicians. On the same date, there were 76,161 Fellows.

Following authorization by the Board of Trustees of employment of an assistant secretary, on April 1, 1948, Dr. Ernest B. Howard became affiliated in that capacity.

An increasing number of constituent state medical associations and component county medical societies are expanding their public relations programs to include the addition to their respective staffs of public relations director or field secretary. Other states are planning to employ public relations firms to assist them in expanding their public relations activities.

The weekly *Secretary's Letter* has become firmly established as a vital news liaison between the office and the profession. More than 3,000 copies go to officers and committee members of national, state, and county societies.

One special phase of public relations is that of publicizing the interim and annual sessions of the Association.

One of the chief functions of the Press Relations Bureau is to write and distribute the weekly news bulletin, *American Medical Association News*, which contains official announcements of the Association and condensations of original articles and editorials appearing in *The Journal*, *Hygeia*, and the special journals. This news release is mailed to approximately 1,200 newspapers, press associations, magazines, radio stations, etc. An estimated 63,000 individual stories were based on these releases. During 1947 the Bureau received and answered more than 4,000 inquiries from newspapers, etc.

Revenues which reached a new peak of \$4,233,580.25 in 1947 were offset by larger expen-

ditures amounting to \$4,284,427.55. The excess of expenditures over income was \$50,847.30. Broadened activities of the Association requiring additional personnel, higher basic wage rates for mechanical and clerical employees and materials purchased at higher prices are accountable for the deficit.

PUBLICATIONS

The circulation of *The Journal of the American Medical Association* has achieved a peak never before achieved by any other medical publication. The weekly average of copies printed in 1947 was 134,310 an increase of 11,475 over 1946. Net paid circulation was 132,664.

The Association continued publication of nine special scientific journals during the year. Publication of a number of books formerly issued by the Association have been transferred to private medical publishers. Royalties from these revert to the general funds.

The average net paid circulation of *Hygeia* during 1947 was 196,046, an increase over the previous year of 39,063. For the first time in seven years, the publication showed a loss. The loss was incurred principally by a decrease in the amount of advertising and an increase in cost of production.

The Eighteenth Edition of the *American Medical Directory* is being compiled and it is hoped that the book will be ready for delivery during early 1949.

LIBRARY

The Library continued to maintain its package library department and general reference service. Answers to approximately 6,000 reference questions were prepared during the year. Requests for the loan of 12,232 periodicals were received. Due to adverse circumstances only one volume of the *Quarterly Cumulative Index Medicus* was published.

ADVERTISING BUREAU

The Cooperative Medical Advertising Bureau continued to assist the state medical journals in securing advertising sales, reviewing copy for the purpose of following standards and servicing each account. The present membership consists of 34 state journals.

PHARMACY AND CHEMISTRY

During the year the Council on Pharmacy and Chemistry encouraged research by discussion and by aiding in the organization of formative plans, made available grants-in-aid, and spread medical

information. Through the Therapeutic Trials Committee several contracts for clinical investigations were executed. Twenty-one medical schools and hospitals were visited and their facilities for research surveyed. One of the activities of the Council is the evaluation of remedies with the view of determining their acceptance for inclusion in *New and Nonofficial Remedies*.

CHEMICAL LABORATORY

The Chemical Laboratory of the A. M. A. was instrumental in the development of tests and standards of identity, purity, and potency for 28 new medicinal products during 1947. In addition, it was responsible for examination of nearly 375 individual drug products.

PHYSICAL MEDICINE

Approximately 120 pieces of apparatus were submitted for consideration during the year, of which 29 were considered, inspected, and reported in *The Journal*. Consideration is going forward on the remainder. The booklet *Apparatus Accepted* was completely revised. Eleven articles were published.

The Council has sponsored several exhibits on the medical aspects of atomic energy, and has endeavored to keep the profession informed on latest developments.

FOODS AND NUTRITION

The review of advertising for accuracy of statements constituted the major service of the Council on Foods and Nutrition. All advertisements for Council-accepted products are reviewed by the Council, and all other food advertising accepted by publications of the American Medical Association is passed on by the Advertising Committee.

INDUSTRIAL HEALTH

The Council on Industrial Health has felt that if industrial health programs sponsored by the government, union, and management groups, etc., are well understood by county medical societies and the objectives accurately defined, no serious ethical relationship is involved.

As usual, field services have been mainly pointed at improving the effectiveness of committees on industrial health in state and county societies. The hope that more general practitioners would be attracted to the Eighth Annual Congress on Industrial Health was not realized.

Nearly all medical schools in important industrial areas have been visited during the past year to determine the extent to which industrial medicine is taught. The Council has retained its contact with official agencies concerned with rehabilitation.

NATIONAL EMERGENCY MEDICAL SERVICE

The newly created Council on National Emergency Medical Service was organized in Decem-

ber, 1947. The purpose of the Council is conceived to be development of proper, logical, and timely advice with reference to the medical and associated problems involved in the mobilization of the nation's armed forces, industry, agriculture, and civilian population in time of a national emergency. It is necessary, therefore, to make a continuous, planned, and coordinated study of the numerous problems associated with the mobilization of the nation's manpower, resources, and materials, and to maintain direct and continuous contact with other civilian and governmental medical and allied organizations and agencies as well as with those agencies and organizations involved or responsible for the planning and operation of the national defense in its broadest term.

The Council has arrived at certain conclusions which it believes might be accepted as basic principles. These principles have been summarized in nine points.

HEALTH EDUCATION

A "ruinous" turnover in personnel greatly handicapped the Bureau of Health Education during the year. The Bureau reviewed 24 books for *The Journal* and 21 for *Hygeia* and prepared 32 other contributions to *The Journal* and 74 for *Hygeia*. It originated 42 articles which were published in other periodicals.

In addition to the usual network broadcasts on the National Broadcasting Company, the Bureau initiated a program on the Mutual Broadcasting System, but this did not meet with anticipated public response. The fundamental change in Association policy consisted in making the network broadcasts available for commercial sponsorship from acceptable sponsors. The electrical transcription activity now grows without stimulation.

While the Health and Fitness Division has been concerned with health and fitness problems of the preschool child, the school child, college students, and adults, it has become increasingly evident that the most productive avenue of approach is to be found in working with those groups concerned with the health and fitness of the school child.

Fifty-three new pamphlets were added during the year to the Bureau's list of publications, ten were completely revised and redesignated, 12 were revised in text, and 16 were discontinued.

BUREAU OF INVESTIGATION

During 1947 the Bureau of Investigation continued to function in a fact-finding capacity and in the dissemination to interested persons and groups of information on "patent medicines" and quacks, on fads and faddists, and on frauds, either of a medicinal or a cosmetic nature. The number

of inquiries was about evenly divided as between physicians and laymen.

LEGAL MEDICINE AND LEGISLATION

The Bureau of Legal Medicine and Legislation will omit the routine detailed and factual analyses of medical bills in Congress, leaving such analyses to be presented in the report of the Washington Office of the Council.

During 1947, several drafts of legislation were prepared for the Association of State and Territorial Health Officers anticipatory to the introduction in Congress of a bill to assist the several states in the development and maintenance of local health units organized to provide basic full-time public health services and to assist the states in the training of personnel for local health unit work.

The Bureau has suggested that the Internal Revenue Code be amended to permit, in effect, professional persons to take advantage of the lower corporate income tax rates with regard to income derived from practice as distinguished from income derived from investment. Other income tax reforms have been suggested, such as one permitting physicians to allow in their returns for formulation of pension programs for themselves.

The Bureau has continued its study of state legislation of medical interest.

EXHIBITS AND ECONOMICS

The Bureau of Exhibits administers the Scientific Exhibits at the Annual Session and Interim Session under the Committee on Scientific Exhibit of the Board of Trustees, presents medical exhibits at meetings of state medical associations and other scientific organizations, maintains health exhibits for fairs and expositions, and co-operates with numerous organizations in the dissemination of information concerning graduate medical instruction and health education.

The Bureau of Medical Economic Research was reorganized late in 1946. There are in the Bureau's files 48 publications which were produced between 1931 and 1946, when this department was called the Bureau of Medical Economics. Since the reorganization, the Bureau has published 12 articles, copies of which are available to those who wish to order them.

JUDICIAL COUNCIL

During the year the work of the Judicial Council has been divided between the usual matters presented and the study of the revision of the Principles of Medical Ethics which was assigned to it in 1946.

MEDICAL EDUCATION AND HOSPITALS

The major concerns of the Council on Medical Education and Hospitals during the past year

have been with the projected survey of medical education, the training of general practitioners, the extent to which the facilities for medical education in this country are meeting the nation's needs for physicians, the financial support of medical schools, and the supply and distribution of interns.

SCIENTIFIC ASSEMBLY

The Interim Session held in Cleveland January 5 to 8, 1948, presented many problems to the Council on Scientific Assembly. The General Scientific Meetings, arranged with great care and addressed by eminent speakers, were in general poorly attended. The Council has some doubt regarding ability to keep up the highest standard of program planning if more physicians do not attend the lectures at future interim sessions.

Reasons were not difficult to ascertain: Poor timing of the meeting; location in a city already well supplied with frequent and first-class post-graduate educational programs; a growing movement to organize general practitioners' societies outside of the American Medical Association; the concurrent session of the Congress on Industrial Health; the growth of state programs of a similar nature; and the partial failure to build up an attendance in advance of the meeting.

COUNCIL ON MEDICAL SERVICE

The purpose and functions of the Council on Medical Service briefly are to follow the trends in medical service, to interpret these trends to the members of the A.M.A., and to make suggestions as to improvements. To a certain extent, the Council is a testing ground. After testing activities and projects it has been found that some can best be retained and carried on by the Council, some are more suitable to joint efforts with other departments or organizations, and some are the proper functions of others.

In order to determine the capacity of county medical societies for promoting community leadership in health problems, a pilot questionnaire was sent to 250 selected county societies in the 48 states. A questionnaire also was forwarded the secretary of every state association. Medical societies are rapidly expanding their activities and are anxious to learn of existing experiences.

County medical societies are now receiving the *News Letter*. At present approximately 13,000 persons receive it monthly.

The Board of Trustees and the Council are working for a realistic policy which included the county medical society and the physician in regard to the increasing demand made on them by the numerous so-called voluntary health organizations.

Public interest in compulsory sickness insurance continues unabated. Requests for informa-

tion continue to pour in from physicians, students, and others. There is a complete absence in libraries of reference material presenting arguments against compulsory sickness insurance. The Council has approached the problem in four ways: First, by maintaining a supply of reprints and pamphlets for distribution; secondly, by preparing reference material in bound volume form suitable for library use; thirdly, by making available "loan kits" in cases where detailed reference material is needed; and fourthly, by preparing and making available a bibliography on sickness insurance publications.

The picture today on medical society-sponsored medical care plans shows more than 7,500,000 persons covered, over 50 per cent enrollment growth in 1947, over 95 voluntary plans in operation in 42 states and the remaining six states and the District of Columbia in the organization stage. The following summary shows the number of insurance agreements of all types in effect: Approximately 30,000,000 persons (one half of the working population)—loss of income due to disability; over 40,000,000—hospitalization; approximately 17,000,000—surgical benefits; and over 6,000,000—medical benefits.

Activities of the Editor

Following are some of the activities recently engaged in by Dr. Jonathan Forman, Editor of *The Journal*:

On Sunday, May 16, talked to The Ohio Farm Bureau (Franklin County), on "Creative Medicine and Rural Health";

Contributed an article on local medical history to the volume honoring Dr. Max Neurberger, noted Austrian physician, on his 83rd birthday.

In the May issue of *The Ohio Magazine*, has an article called "Health from the Ground Up."

In the current issue of *The Land*, quarterly publication of FRIENDS OF THE LAND, has an article entitled "What the Doctors Can't Fix," dealing with a positive approach to health.

Recently published articles including: "The Worthington School and Thomsonianism," *Bulletin of the History of Medicine*, 1947; and "Do You Want To Be an Allergist?" *Journal of Phi Rho Sigma*, 1948.

Appeared as a guest lecturer in the postgraduate course given at the University of Michigan, Ann Arbor, where he spoke on bronchial asthma, gave a clinical demonstration on the same subject, and gave a lecture on "Drug and Serum Allergy."

On May 26 was guest of Zeta Chapter of Phi Rho Sigma and spoke on "The Practice of Medicine As We Find It Today." He is past national president of the fraternity.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since April 17, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

BELMONT COUNTY

David Brown, Bellaire

CLARK COUNTY

George A. Smith, Springfield

COLUMBIANA COUNTY

George F. Cain, East Liverpool

CUYAHOGA COUNTY

Benjamin Abrams, Cleveland

Leonard J. Alperin, Cleveland

Eric Bell, Cleveland

William H. Bond, Brewster

Thomas H. Bottomley, Jr., Cleveland

Edward S. Brown, Cleveland

Leland E. Campbell, Cleveland

Charles J. Centa, Euclid

Albert H. Dyson, Cleveland

Lucille C. Fisk, Cleveland

Leonard B. Goldberg, Cleveland

M. Gustafson, Cleveland

James R. Hart, Cleveland

W. M. Hegarty, Jr., Cleveland

John A. Holland, Cleveland

J. J. Leedy, Cleveland

Richard C. Light, Cleveland

Ralph C. Lohrey, Euclid

Stuart B. Marks, Cleveland

Stanley J. Matt, Cleveland

Morton L. Miller, Cleveland

Michael A. Petti, Cleveland

Maynard A. Pike, Cleveland

Herman Rice, Temple, Texas

Richard C. Schneider, Cleveland

Oliver K. Scott, Cleveland

Clarence B. P. Slaughter, Cleveland

Clarence M. Smith, Cleveland

Robert O. Turek, Cleveland

Ralph E. Vitolo, Cleveland

H. A. Zimmerman, Cleveland

FRANKLIN COUNTY

Richard L. Everhart, Columbus

John R. Frantz, Worthington

Robert L. Marshall, Columbus

Bert E. Moore, Columbus

D. Donald Pellicciari, Columbus

Claude Starr-Wright, Columbus

HAMILTON COUNTY

Jerome R. Berman, Cincinnati

Alfred W. Erb, Cincinnati

Bernard D. Gillman, Cincinnati

Max L. Lurie, Cincinnati

Stuart A. Safdi, Cincinnati

Robert T. Thompson, Cincinnati

HARDIN COUNTY

Louis A. Black, Kenton

LORAIN COUNTY

Robert L. Adair, Lorain

MARION COUNTY

Morten S. Olson, Marion

MUSKINGUM COUNTY

Robert C. Beardsley, Zanesville

Joseph C. Greene, Zanesville

RICHLAND COUNTY

Edward H. Beilstein, Mansfield

Carl M. Quick, Mansfield

STARK COUNTY

Sidney Larson, Canton

D. L. Ream, Hartsville

Leroy B. Schumaker, Canton

SUMMIT COUNTY

Edward F. Hellwig, Akron

Theodore R. Marvin, Cuyahoga Falls

Howard Oliver Musser, Akron

George W. Smith, Jr., Akron

TUSCARAWAS COUNTY

Charles R. McReynolds, Baltic

UNION COUNTY

May B. Zaugg, Marysville

Paul Richard Zaugg, Marysville

The death rate from all causes among U. S. life insurance policyholders reached a new low in 1947 at 737.9 per 100,000, with declines shown for practically all causes of death including heart disease and cancer, the Life Insurance Association of America reported. The 737.9 rate compares with 773.1 in 1946 and 763.9 in 1942, the previous lowest rate. These results are indicated by the experiences of companies representing 73 per cent of the ordinary and industrial life insurance policies in force in all U. S. companies.

Proceedings of The Council . . .

Suggested Changes in V. A. Fee Schedule Approved; Plans For 1949 Annual Meeting Started; Other Important Business Transacted

A regular meeting of The Council of the Ohio State Medical Association was held on Sunday, June 6, 1948, in the State Headquarters Office, Columbus. All members of The Council were present. Others attending the meeting were: Dr. Jonathan Forman, Editor of *The Journal*; Doctors Skipp, Sherburne, Wiseley, and Woodhouse, delegates to the American Medical Association; Dr. L. Howard Schriver, President, and Mr. Charles H. Coghlan, Executive Vice-President, of Ohio Medical Indemnity, Inc., respectively; and Secretaries Nelson, Saville, Page, and Moore.

On motion duly made, seconded and unanimously carried, the minutes of the meetings of The Council held on March 7, March 29, and April 1 were approved.

A report on membership was given by the Executive Secretary, showing a total membership, as of June 4, 1948, of 7,103, of which 24 are military members whose dues are waived; compared to a total membership of 7,106 as of December 31, 1947.

Amendments adopted by the Miami County Medical Society on April 9, 1948, to Article III, Section 2, and Chapter 1, Section 10, of the Constitution and By-Laws of that society were approved by The Council on motion duly made, seconded and unanimously carried.

HEALTH ADVISORY COMMITTEE PLANNED

The Council was advised that plans are under way for the establishment of a committee, consisting of representatives of state-wide organizations, to make a study of the present public health setup in Ohio with possible recommendations for improvements, and that the Ohio State Medical Association had been requested to appoint a representative on such committee.

On motion duly made, seconded and unanimously carried, The Council approved the project and authorized President Brindley to appoint a representative on such committee. Pursuant to this action, Dr. Brindley designated the Executive Secretary to represent the State Medical Association on the committee.

PROPOSED CHANGES IN V. A. SCHEDULE

The Council received a report from the Committee on Medical Care of Veterans, in which certain recommendations were made regarding proposed revisions in the agreement and fee schedule governing the Ohio program for the

medical care of veterans. The committee recommended that these recommendations, if approved by The Council, be submitted to the Veterans Administration for incorporation in the agreement and fee schedule when the matter of renewal on July 1, 1948, is considered. Action of The Council on this matter, on motion duly made, seconded and unanimously carried, was as follows:

1. That Item 0039 be amended to read as follows: "Neuropsychiatric examination, \$15.00."

That 0039A be amended to read as follows: "Psychiatric examination, \$10.00."

That Item 0040 be amended to read as follows: "Neurological examination, \$10.00."

That Item 0040A be eliminated from the fee schedule.

2. That Section (5A) of the agreement between the Ohio State Medical Association and the Veterans Administration be amended by eliminating the last sentence and substituting in lieu thereof the following:

"It is understood that unusually involved cases and services not scheduled, or where there is a controversy, will be subject to review and recommendation by the Ohio State Medical Association to the Veterans Administration for determination of the appropriate fee in event an agreement cannot be worked out between the participating physician and the chief medical officer and the Veterans Administration Regional Office concerned."

3. That Section (9) of the agreement between the Ohio State Medical Association and the Veterans Administration be amended by adding the following sentence:

"Representatives of the Veterans Administration shall be invited to be present and participate in any hearings which may be held on such cases."

4. That the following be inserted in the fee schedule between Items 0023 and 0024:

"FEE FOR NIGHT CALLS BY SPECIALISTS: When a specialist makes an examination or renders treatment at home or hospital between 7:00 P. M. and 8:00 A. M., the fee shall be as listed in this schedule, plus an additional amount of \$3.00."

5. That the following item be inserted between Items 0044 and 0045:

"0044A, Eye examination without refraction, \$5.00."

6. That the following items and fees be inserted in the fee schedule at the proper places and that Item 9108 be amended:

"0055—Catheterization of eustachian tubes, \$5.00.

"0305—Biopsy (without report of tissue examination), \$5.00.

"0306—Tissue examination (microscopic), \$5.00.

"0307—Papanicolaou test for early cancer, \$5.00.

"0627—Thymol turbidity, liver function, \$3.00.

"0628—Cephalin flocculation, \$3.00.

"0629—Bromsulfalein, \$4.00.

"0630—Other liver function tests; namely, Lipase, Phenolsulfonphthalein, Phenoltetrachlorophthalein, each \$4.00.

"0704—Examination for parasites and ova without use of concentration method, \$3.00.

"4714—Wart removal by use of carbondioxide, \$3.00.

"5025—Prostatic massage, \$3.00.

"5026—Dilatation of urethra (soundings), \$5.00.

"5027—Urinary bladder irrigation, \$5.00.

"8120—Vertebral nerve block, \$10.00."

Amend Item 9108 to read as follows:

"Gallbladder, Graham technique, or similar technique, \$20.00."

"9136—Fluoroscopy of part of body or limb (without necessity for locating foreign body), \$5.00."

7. That there be no change in the schedule relative to the "AA" items.

8. That Item 0028 be amended to read as follows:

"0028—Physical examination of lungs, \$7.50."

That Item *0030 be amended to read as follows:

"Gastrointestinal, including barium meal and enema, X-ray and fluoroscopy with preliminary KUB film, \$35.00."

That the item "Gastrointestinal, barium meal and enema" under the heading "Total Fees For Certain X-Ray Procedures" be amended to read "\$35.00" instead of \$40.00 in both columns.

9. That the figures in the last two lines of the first paragraph of the paragraph headed "Example," immediately preceding "Part I" of the fee schedule, be amended to read "\$3.75" and "\$18.75," respectively.

PROTEST TO BE MADE

There was a general discussion of Veterans Administration activities and, on motion duly made, seconded and unanimously carried, The Council went on record as registering a strenuous protest against the present procedure, which permits the hospitalization in veterans' hospitals

of persons without service-connected disabilities, and who are economically able to provide medical care and hospitalization at their own expense. The motion specified that this matter should be brought to the attention of proper officials and members of the Congress.

REPORT TO BE MADE LATER

Dr. Swartz, chairman of a special subcommittee, which had been appointed to investigate a controversy between the physicians in Summit County and an Akron hospital on matters of staff privileges, reported that his committee had had several conferences on this question and that voluminous additional data had been assembled for study. He requested that additional time be given to his committee for the investigation and for preparation of a report for The Council. On motion duly made, seconded and unanimously carried, this request was granted.

1949 ANNUAL MEETING PLANS

The Executive Secretary reported for the Committee on Scientific Work, which had held a meeting in the Columbus Office on Saturday, June 5, for the purpose of making preliminary arrangements for the 1949 Annual Meeting, which will be held in Columbus the week of April 17.

A recommendation of the committee that the length of the annual meeting be extended in order to permit the scheduling of additional instructional courses—specifically that the annual meeting open Tuesday morning, April 19 at 9:00 a. m. and close officially Friday noon, April 22—was approved by The Council on motion duly made, seconded and carried.

DATES FOR 1950 AND 1951

Dates and places for the annual meetings in 1950 and 1951 were approved as follows, on recommendation of the committee, and on motion duly made, seconded and unanimously carried: 1950 Annual Meeting the week of May 14, Cleveland; the 1951 Annual Meeting the week of April 22, Cincinnati.

SCIENTIFIC EXHIBIT

On proper motion duly made, seconded and unanimously carried, The Council adopted the following procedures with respect to the scientific exhibit:

1. That a certificate be prepared and issued for the first, second, and third awards.

2. That a proper emblem or placard be prepared for posting at the exhibits of those winning the awards.

3. That the awards be made no later than the second day of the annual meeting.

4. That the Committee on Scientific Work and the President be empowered to select a Committee on Scientific Awards and to draft a state-

ment of principles and standards to govern the scientific exhibit and the awards.

CONFERENCE IN CHICAGO

A communication from the Secretary of The Council on Medical Service of the American Medical Association, requesting the Association to send an official representative to a conference in Chicago on June 19 for the purpose of discussing a proposal for the merger into one organization the Blue Shield and Blue Cross Commissions, was discussed. Participating in the discussion, in addition to members of The Council, were: Dr. L. Howard Schriver, Cincinnati, President of the Blue Shield Commission and President of Ohio Medical Indemnity, Inc., and Mr. Charles H. Coghlan, Columbus, Executive Vice-President of Ohio Medical Indemnity, Inc., who with Dr. Mundy, a member of The Council and a member of the Board of Directors of Ohio Medical, had attended a meeting in Los Angeles the latter part of March at which this question was considered and acted upon.

Following the lengthy discussion, The Council, on motion duly made, seconded and unanimously carried, instructed Dr. Brindley, the President, to attend the June 19 conference representing the Ohio State Medical Association.

A communication addressed to the officers, delegates, and members of the Ohio State Medical Association from Dr. Schriver, President of Ohio Medical Indemnity, Inc., and which was published in the June issue of *The Ohio State Medical Journal*, was read and discussed. On motion duly made, seconded and unanimously carried, The Council expressed its appreciation to Dr. Schriver for the sentiments expressed in the communication, and endorsed his statements with respect to certain abuses on the part of a few physicians in dealing with Ohio Medical subscribers.

COMPLAINTS TO BE INVESTIGATED

A communication from Mr. Coghlan, Executive Vice-President of Ohio Medical Indemnity, Inc., was submitted to The Council for its consideration. The communication pointed out that by action of the Executive Committee of Ohio Medical Indemnity, Inc., the attention of The Council is called to a number of complaints which have been registered by subscribers, that the charges made by the physician were greatly in excess of the indemnity paid by Ohio Medical. Specific cases were cited in which there was some evidence indicating overcharging on the part of the physician. The letter pointed out that these cases were submitted to The Council for any action which The Council desired and can take under the Constitution and By-Laws of the State Association.

Following an extensive discussion of these

matters The Council, on motion duly made, seconded and unanimously carried, referred the question to the Judicial and Professional Relations Committee, specifically requesting that committee to make an investigation, interview the physicians concerned, and report its findings and recommendations to The Council.

LEGISLATIVE PROPOSALS

An analysis of S. 2588, now pending in the Congress, to provide Federal grants and scholarships for medical education, was presented to The Council for its information. It was pointed out that the American Medical Association will not support the bill, believing that it gives too much control to the Federal Government on matters of medical education. On motion duly made, seconded and unanimously carried, The Council endorsed the views of the American Medical Association on this proposal.

The Executive Secretary called attention to a telegram received by representatives of the Auxiliary to the Ohio State Medical Association from a district representative director of the Woman's Auxiliary to the American Medical Association, in which the Ohio Auxiliary was asked to make protests to Ohio members to the Congress on certain provisions of the pending Selective Service measures.

Following a discussion, The Council, on motion duly made, seconded and unanimously carried, instructed the President to write the American Medical Association to the effect that the Ohio State Medical Association believes that this procedure is improper and that all national legislative matters should be handled directly by the A.M.A. and the Ohio State Medical Association, leaving the matter as to whether the Ohio Auxiliary should or should not be requested to support or oppose legislation to the discretion of the proper officials of the Ohio State Medical Association.

SELECTIVE SERVICE QUESTIONS

The Executive Secretary submitted a report from the Committee on National Emergency Medical Service. The report pointed out what the committee had done on matters involving pending Selective Service measures. (See article on page 635 of the June issue, *The Ohio State Medical Journal*.) On motion duly made, seconded and unanimously carried, the report of the committee, including the actions of the committee on the Selective Service question, was approved.

STATE DISASTER PLAN

The committee also submitted a suggested communication to Governor Herbert on the matter of a State Disaster Plan. On motion duly made, seconded and unanimously carried, the statement, reading as follows, was approved, and

Dr. Sherburne, chairman of the committee, was authorized to transmit the communication to the Governor:

"The Ohio State Medical Association, through its Committee on National Emergency Medical Service, has devoted considerable time to the study of the problems involving the provision of medical care and hospitalization in any 'State Disaster Plan' which might be placed in operation by the State of Ohio. You may recall our conference with you on the subject of a 'State Disaster Plan' this past March at which time you informed us of the consideration which your office was giving this matter. Since that date the Office of the Secretary of Defense has established a Civil Defense legislative planning department under Mr. Russel Hopley. At the same time the American Red Cross is developing plans for the protection of the civilian population in the event of a national emergency.

"The Ohio State Medical Association, therefore, respectfully presents for your consideration the following recommendations and suggestions with reference to the establishment of policy, plans, and programs involving medical care and hospitalization in a 'State Disaster Plan' for the State of Ohio:

"1. The Governor, being the appointing authority for the personnel of a 'Disaster Plan Agency,' should as soon as possible appoint a 'Civilian Medical Advisory Committee' responsible to the Governor and available to advise him and the director of the 'State Disaster Plan' on all matters relating to the medical care and hospitalization of disaster casualties, victims and evacuees.

"2. The 'Civilian Medical Advisory Committee' would be responsible for the following:

"(a) Advising the Governor and his designates in the immediate development of the medical aspects of the over-all 'State Disaster Plan' for the State of Ohio.

"(b) The development of policies and procedures for the medical care and hospitalization of disaster casualties and victims.

"(c) The development of an educational program for members of the medical and allied professional groups in the special handling of problems related to all forms of disaster, including those resulting from the use of special or unconventional weapons.

"(d) The development of plans for the survey and continued appraisal of medical and allied professional personnel, facilities, and supplies to determine their availability in the event of disaster.

"(e) The development of plans for the coordination of the medical and hospital activities of the 'Ohio Disaster Plan' with similar activities of bordering states.

"The Ohio State Medical Association restates its vital interest in the health and medical care of the civilian population of our State and awaits the pleasure of you and your staff in the development of a timely and logical program to protect our citizens should a national emergency once again face our country."

REPORT OF SCHOOL HEALTH COMMITTEE

The following report of the Committee on School Health was submitted for the information of The Council and, on motion duly made, seconded and unanimously carried, was approved:

"A meeting of the newly appointed Committee on School Health was held in the State Headquarters Office on Sunday, May 16, 1948. All members of the committee, except Dr. John F. Miller, Newark, were present. Others attending were: Dr. A. A. Brindley, Toledo, and Dr. Carl A. Lincke, Carrollton, President and President-Elect, respectively, of the State Association; Messrs. Nelson, Saville, Page, and Moore of the State Headquarters Office.

"Following a brief statement by Dr. Wilzbach and Dr. Brindley, outlining the reasons for the appointment of the committee, Dr. Wilce reviewed the joint activities of the Department of Education, Department of Welfare, and Department of Health; activities in physical fitness carried on during World War II; and the activities of the National Committee on Physical Fitness, including conferences at the A.M.A. Headquarters, Chicago, and in Washington which he had attended as representative of the Ohio State Medical Association.

"A report on the program of the Department of Education with the five state universities and the University of Cincinnati, financed by funds from the Kellogg Foundation, was reviewed by Dr. Wilce and Dr. Shaffer.

"Dr. Wilzbach and Dr. Wilce presented a report on the conference on school health in the Fall of 1947 at Chicago under the sponsorship of the A.M.A.

"Reports on workshops held at Russell's Point under the Division of Health, Physical Education, Recreation and Safety of the Department of Education were made by Dr. Wilce, Dr. Shaffer, and Dr. Wilzbach, the most recent one having been held this week-end.

"Bulletins on school health issued by the A.M.A. and other agencies were reviewed briefly and copies distributed to members of the committee. The Executive Secretary was instructed to secure copies of other bulletins referred to.

"This being the first meeting of the committee, considerable time was devoted to a review of activities such as described above, which have been carried on in the state.

"After these discussions, on motion duly made, seconded and carried, the chairman was authorized to appoint a subcommittee to prepare a statement on principles, policies and procedures on the question of school health which, after approval at the next meeting of the committee, could be sent to county medical societies with a request that each county society appoint a committee on school health to act as a local auxiliary committee to the Committee on School Health of the State Association and to take the leadership on matters of school health for their respective county medical societies.

"Dr. Wilzbach announced that he would appoint this committee in the very near future and that an effort would be made to have a statement prepared which could be considered by the main committee at a meeting to be held sometime in July if possible."

LABORATORY CONFERENCE

The Executive Secretary reported on a conference held in the State Headquarters Office on May 19, at which representatives of the Ohio Department of Health, the Ohio Society of Clinical Pathologists, and the Ohio State Medical Association discussed proposed changes in the regulations governing laboratories approved for premarital and prenatal blood tests for syphilis. The report indicated that progress in working

How Councilors Spent Sunday, June 6



The above unposed photo shows members of The Council and others as they met on June 6 in the Association's Columbus Headquarters Office. Clockwise around the table are: H. M. Clodfelter, E. O. Swartz, R. J. Foster, Chester P. Swett, Carll S. Mundy, Fred W. Dixon, H. C. Messenger, R. L. Rutledge, immediate Past-President, Jonathan Forman (with hand raised), Editor of *The Journal*, A. A. Brindley, President, Mr. Charles S. Nelson, executive secretary; Mr. George H. Saville (near window), director of public relations, H. P. Worstell, Treasurer, Paul A. Davis, John S. Hattery, J. P. McAfee, Carl A. Lincke, President-Elect, and J. Craig Bowman. Dr. William M. Skipp, Youngstown, a Delegate to the A. M. A. can be seen to the extreme left of the picture. Other Delegates present but not shown were Dr. George A. Woodhouse, Pleasant Hill; Dr. Frank M. Wiseley, Findlay; Dr. Howard Schriver, Cincinnati; and Dr. C. C. Sherburne, Columbus.

out mutually agreeable regulations had been made and that a subsequent report on this matter will be made to The Council at a future meeting.

NATIONAL HEALTH ASSEMBLY

The Executive Secretary referred to his report on the National Health Assembly held recently in Washington and printed in the June issue of *The Journal*.

REPORT OF COMMITTEE ON EDUCATION

A report from the Committee on Education on a meeting held on Saturday, May 15, was reviewed and discussed. The report pointed out that the committee is making a study of certain questions, such as, the shortage of nurses, shortage of interns, and modification of medical school curricula, through subcommittees and that the committee hopes to have some specific recommendations on these matters for consideration by The Council at an early date.

The committee also reported that it is planning to arrange for one-day postgraduate programs in various parts of the State this Fall. Subjects tentatively decided upon for these programs are as follows: heart disease; tuberculosis; and common dermatological disorders. It was

pointed out that the committee will meet early in July to work out final details for these postgraduate assemblies. On motion duly made, seconded and unanimously carried, the report of the committee was approved.

LETTERS FROM NURSE GROUPS

A communication from the Ohio State League of Nursing Education, requesting the Ohio State Medical Association to appoint a representative on an advisory committee to work with the State Department of Education, Vocational Education Division, on plans to guide communities desiring to set up practical nurse training programs through local Boards of Education, was read and discussed. On motion duly made, seconded and unanimously carried, the President was instructed to serve on such advisory committee.

A communication from the President of the Practical Nurse Association of Ohio, Inc., asking the Association to name representatives to two committees which will work on matters involving proposed legislation for the licensing of practical nurses in Ohio, was read and discussed.

On motion duly made, seconded and unanimously carried, the Executive Secretary was in-

structed to inform that organization that the Ohio State Medical Association has a committee working with the Ohio State Nurses' Association on this and similar questions and that it is felt that matters of legislation should be worked out through the Ohio State Nurses' Association with which representatives of the Ohio State Medical Association are already working in an advisory capacity.

EMBLEMS FOR 50-YEAR MEN

The Council discussed the action of the House of Delegates, authorizing the issuance of certificates of distinction and gold pins to all members of the Association who have been engaged in practice for at least 50 years. On motion duly made, seconded and unanimously carried, the Executive Secretary was instructed to obtain quotations on a suitable gold pin or button and on proper certificates which would be issued to members, or former members, who have been practicing for at least 50 years. The motion also stated that the presentation of these emblems should be made by the Councilors at specially arranged meetings of the county medical societies honoring the 50-year men.

No action was taken on the matter of issuance of membership certificates or plaques annually to all members of the Association, as recommended by the House of Delegates, but the President instructed Dr. Rutledge to investigate this matter, secure additional data, and to report at a future meeting of The Council.

MISCELLANEOUS QUESTIONS

The question of the American Red Cross blood donor program was discussed. It was pointed out that this matter probably will be brought before the House of Delegates of the American Medical Association at the June meeting at Chicago. No action was taken pending action of the A.M.A.

A communication from the Indianapolis Medical Society, asking support for a resolution opposing compulsory attendance at meetings, presumably meetings of hospital staffs, was read and discussed. No action was taken and the matter was left to the discretion of the Ohio delegates to the A.M.A.

Following a report by members of The Council on activities in their districts and visits to county medical societies, The Council adjourned to meet at the Granville Inn on Friday evening, Saturday and Sunday, September 17, 18 and 19.

Attest: CHARLES S. NELSON,
Executive Secretary.

Ohio State University has conferred the honorary degree of doctor of laws on Dr. Verne A. Dodd, Columbus, professor of surgery at the O. S. U. College of Medicine and chief of staff of University Hospital.

Cleveland Academy Reports Study Of 300 Emergency Calls

A recent study of 300 "emergency" calls for doctors in Cleveland was made by H. Van Y. Caldwell, executive secretary of the Cleveland Academy of Medicine, a report of which gives some interesting sidelights on the "off-hours" calls for emergency medical attention.

The 300 calls came to the Academy's headquarters which operates a 24-hour-a-day telephone service. The study includes calls made between January 28 and February 23, 1948, most of them between the hours of 6 p. m. and 8 a. m. The Academy bears the expense of maintaining the emergency service.

The average time elapsing between the time a call was received and a doctor contacted who was willing and able to make the call was 8.7 minutes. Eliminating 14 unusually long calls, the average elapsed time would have been only 6.8 minutes.

The most difficult hour to reach doctors was from 6 to 7 p. m. Calls after midnight averaged approximately five minutes.

The study showed that 77 Academy members took care of the 300 calls. Fifteen members took care of 200 calls, or 66 per cent of the load. In 214 of the calls, or 71 per cent, the first doctor reached by the operator agreed to make the call. In 40 cases, the second doctor, and in 29 calls the third doctor responded. In two calls it was necessary to contact eight doctors.

By drawing conclusions from symptoms related by callers, it was estimated that 72 of the 300 calls were in behalf of babies and young children with high temperatures, croup, convulsions, etc. The second largest group, or 53 calls, included persons apparently suffering from heart and cerebral attacks. Other categories were as follows: Adults with colds and fever, 42; accidents, mostly consisting of falls and abrasions, 17; women in hysterics or fainting, 14; miscarriages, 5; persons who had been drinking, 4; attempted suicides with poison, 3; and violent mental cases, 3. Causes for the remaining 87 calls were not evident.

Industrial Injury Claims

During 1947, there were 289,626 injury and occupational disease claims filed with the Industrial Commission of Ohio, according to *The Monitor*. These included 1,012 death claims, 11 permanent total disabilities, and 2,658 amputations. The latter figure represents the loss to Ohio employees of 152 eyes, 38 arms, 23 hands, 45 legs, 5 feet, 1,750 whole fingers, 1,399 parts of fingers, and 120 toes. The figures are given without regard to the Commission's decision as to their compensability.

Hospital Training Facilities . . .

A. M. A. Report Shows 42 Ohio Institutions Offering 463 Internships While 62 Are Providing Openings for 806 Residencies and Assistants

FORTY-TWO Ohio hospitals are this year offering a total of 463 internships, according to the annual report on internships and residencies of the Council on Medical Education and Hospitals of the American Medical Association, as published in the May 1 issue of *The Journal of the A. M. A.*

Sixty-two Ohio hospitals are offering 806 assistant residencies, residencies, and fellowships, not including two Veterans Administration hospitals which are offering an additional 69 residencies. The number of residencies and fields of residency training for each hospital are given under the subheading "Residencies," while the number of internships are shown in the accompanying table.

NUMBER OF INTERNSHIPS

As of April 1, 1948, 798 hospitals in the United States were approved for intern training, as well as nine outside the country. Those listed include 41 under Federal control, 120 under governmental control other than Federal, 16 proprietary institutions, 295 church sponsored, and 335 non-profit associations. They offer a total of 9,118 internships including 16 in the Canal Zone, 18 in Puerto Rico, and 26 in Hawaii. These are not all available annually, however, since 979 of the total number are for periods in excess of 12 months. Since August, 1947, the Council has approved 17 new hospitals.

In the Federally controlled group, the U. S. Army now offers 108 internships, the U. S. Navy 117, the U. S. Public Health Service 115 and the Federal Security Agency 30.

For many years the number of approved internships has been greater than the number of physicians graduated annually. Prior to the war, however, relatively few approved internships were not filled. Since the war a number of approved internships have remained vacant.

The annual demand for interns has been increased not only by the establishment of additional internships but also by the fact that a much greater proportion of the internships are now offered for a one year period only. In 1939 there were 1,738 internships of over one year's duration while in 1948 the number of such internships is only 979. The decline in the number of the longer type internships is attributable in part to the fact that more physicians enter residency training after the first year of internship, with a consequent lessening of demand for the two-year plans, and to the fact that some

hospitals have been unable as yet to convert from their shorter wartime programs. The teaching group offered 46.8 per cent of the total number of internships while the non-teaching group accounted for 53.2 per cent. Teaching hospitals reported 8.6 per cent of their positions unfilled, while 32.2 per cent of the positions in the non-teaching group were vacant.

RATIO TO ADMISSIONS

It is apparent that with an increase in the number of annual admissions, an approved hospital will require additional interns.

Average admissions per hospital for both groups increased by 35 per cent from 1939 to 1948, with an increase in the teaching group of 28 per cent and an increase of 38 per cent for the non-teaching hospitals. In addition to the increased number of admissions per hospital, there was an appreciable drop in the number of interns on duty in the non-teaching hospitals. As a consequence the number of admissions per intern, in this group, has increased by approximately 70 per cent. In the teaching hospitals, it has increased about 25 per cent during the same period. The apparent disproportion of interns in teaching hospitals, however, must be considered in the light of the duties involved and the number of patients with which the intern is directly concerned. In the smaller non-teaching hospitals many of the patients admitted are not available to the intern for instructional purposes.

AUTOPSIES

The majority of hospitals approved had little difficulty in meeting the minimum requirement of 15 per cent. Of the teaching hospitals, 122 (66 per cent) had rates of 40 per cent or over; in the non-teaching group, 214 (38 per cent) were able to maintain a rate of this level.

STIPEND

Data concerning monthly stipends are available for 738 of the hospitals studied. Of this group, 60 teaching and 24 non-teaching hospitals (11 per cent) paid no stipend; 98 teaching and 240 non-teaching (46 per cent) paid \$50 or less. An additional 265 (36 per cent) offered amounts from \$51 to \$100, while 51 hospitals (7 per cent) stipulated amounts in excess of \$100.

RESIDENCY TRAINING

Hospital facilities for the training of resident physicians have increased tremendously in recent

years. Compared with 1941, when 5,256 residencies were available, the present total of 15,172 as of April 1, 1948, represents an increase of nearly 200 per cent. These services include 12,402 approved residencies in non-Federal hospitals and 2,770 in the Federal group, including 2,118 in hospitals operated by the Veterans Administration. The number of hospitals currently approved by the A.M.A. for residency training is 1,102.

General surgery offers the greatest number of residencies, 2,977 in all, whereas internal medicine has 2,880 not counting 47 in allergy, 55 in cardiovascular disease, 3 in gastroenterology and 418 in pulmonary diseases. Psychiatry can accommodate 1,618 applicants, obstetrics and gynecology 1,145, radiology 833, pathology 794, pediatrics 791, ophthalmology and otolaryngology 738, orthopedics 718, anesthesiology 487, pulmonary diseases 418, and urology 407.

RESIDENCIES

Throughout the country, 15,172 assistant residencies, residencies and fellowships were offered by 1,102 hospitals. All hospitals on the approved intern list are likewise accredited for general residencies which represent general house staff assignments following internship.

In Ohio hospitals the number of assistant residencies, residencies and fellowships offered in respective specialty fields are as follows: Anesthesiology 16; contagious diseases 4; dermatology and syphilology 13; general residency 8; internal medicine 159; neurological surgery 9; neurology 3; obstetrics 38; obstetrics and gynecology 37; ophthalmology 11; otolaryngology 11; orthopedic surgery 44; pathology 43; pediatrics 57; physical medicine 1; proctology 4; psychiatry 49; pulmonary diseases 21; radiology 50; surgery 215; thoracic surgery 1; and urology 12. The foregoing figures do not include residencies offered at the two Veterans Administration hospitals.

The following summary shows the number of assistant residencies, residencies, and fellowships, and specialty fields in which they are offered by respective Ohio hospitals:

City Hospital, Akron—Internal medicine 3; obstetrics and gynecology 5; orthopedic surgery 5; pathology 2; radiology 2; and surgery 9.

Children's Hospital, Akron—Orthopedic surgery 2; pediatrics 5; and surgery 1.

Peoples Hospital, Akron—Internal medicine 2; obstetrics 3; radiology 1; and surgery 3.

St. Thomas Hospital, Akron—Internal medicine 2; obstetrics 2; and surgery 4.

Aultman Hospital, Canton—Internal medicine 4; obstetrics and gynecology 7; pathology 2; and surgery 9.

Mercy Hospital, Canton—Internal medicine 2;

obstetrics and gynecology 4; radiology 11; and surgery 7.

Bethesda Hospital, Cincinnati—Obstetrics 3; and pathology 1.

Children's Hospital, Cincinnati—Orthopedic surgery and pediatrics 16.

Christ Hospital, Cincinnati—Anesthesiology 1; internal medicine 4; neurological surgery 1; pathology 1; psychiatry 1; and surgery 5.

Cincinnati General Hospital—Anesthesiology 1; dermatology and syphilology 4; internal medicine 29; neurological surgery 2; neurology 1; ophthalmology 2; otolaryngology 2; obstetrics 5; orthopedic surgery 16; pathology 6; pediatrics 16; psychiatry 14; radiology 7; and surgery 22.

Deaconess Hospital, Cincinnati—Internal medicine 1; and surgery 2.

Good Samaritan Hospital, Cincinnati—Internal medicine 4; pathology 1; and surgery 8.

Jewish Hospital, Cincinnati—Internal medicine 6; orthopedic surgery 1; pathology 1; radiology 1; and surgery 7.

Dunham Hospital, Cincinnati—Pulmonary diseases 6.

St. Mary's Hospital Cincinnati—Surgery 3.

Longview State Hospital, Cincinnati—Psychiatry 3.

City Hospital, Cleveland—Contagious diseases 4; dermatology and syphilology 4; internal medicine 16; obstetrics 3; ophthalmology 2; otolaryngology 2; pathology 6; pulmonary diseases 2; radiology 4; surgery 18; thoracic surgery 1; and urology 2.

Cleveland Clinic Foundation Hospital—Anesthesiology 1; dermatology and syphilology 3; internal medicine 17; neurological surgery 5; neurology 2; orthopedic surgery 6; otolaryngology 2; pathology 1; physical medicine 1; psychiatry 2; radiology 6; surgery 18; and urology 5.

Cleveland State Receiving Hospital—Psychiatry 12.

Cleveland State Hospital—Psychiatry 2.

Fairview Park Hospital, Cleveland—Obstetrics 2; and surgery 3.

Lutheran Hospital, Cleveland—Obstetrics 1; radiology 1; and surgery 4.

Grace Hospital, Cleveland—General Residency 2.

Mt. Sinai Hospital, Cleveland—Anesthesiology 1; internal medicine 3; obstetrics 1; obstetrics and gynecology 1; orthopedic surgery 2; pathology 2; radiology 1; and surgery 3.

St. Alexis Hospital, Cleveland—Internal medicine 1; radiology 1; and surgery 6.

St. Ann's Maternity Hospital, Cleveland—Obstetrics 2.

St. John's Hospital, Cleveland—Internal medicine 2; obstetrics 3; surgery 4.

St. Luke's Hospital, Cleveland—Anesthesiology

OHIO HOSPITALS APPROVED FOR INTERN TRAINING, WITH NUMBER OF INTERNSHIPS AVAILABLE AND OTHER PERTINENT DATA.

	Control	Capacity	Total Patients Admitted	% Service Cases	% Private Patients Assigned to Interns	Internships	Affiliated Service	Outpatient Service	Autopsy Percentage	Stipend
City Hospital, Akron	NPA	489	15,712	7	100	16	(182)	Req	47	30
Peoples Hospital, Akron	NPA	260	11,970	15	100	6	(182)	Req.	36	50
St. Thomas Hospital, Akron	Church	235	8,871	3	100	8	(183)	Req	32	75
Aultman Hospital, Canton	NPA	365	11,303	5	95	10	No	Req	57	50
Mercy Hospital, Canton	Church	272	8,345	—	—	6	No	None	32	50
Christ Hospital, Cincinnati	Church	439	10,704	15	95	14	(184)	Req	40	30
Cincinnati Gen. Hosp.	City	915	14,757	100	—	40	(185)	Reg	47	No
Deaconess Hospital, Cinci.	Church	198	4,968	15	100	5	(186)	Req	23	75
Good Samaritan Hosp., Cinci.	Church	628	15,632	30	95	18	No	Req	38	60
Jewish Hospital, Cinci.	NPA	300	9,233	3	100	9	(187)	Op	52	40
St. Mary's Hosp., Cinci.	Church	230	5,265	35	28	8	No	Req	26	75
City Hospital, Cleveland	City	1,135	14,470	100	—	36	No	Req	54	40
Evangelical Deaconess Hosp. Cl.	Church	164	6,097	2	65	4	No	None	18	75
Fairview Park Hosp., Cl.	Church	201	7,574	3	100	6	No	Req	44	75
Glenville Hospital, Cl.	NPA	135	5,334	—	—	4	—	None	23	75
Lutheran Hospital, Cl.	Church	160	5,278	2	98	4	No	None	44	75
Mt. Sinai Hospital, Cl.	NPA	262	9,726	12	100	12	No	Req	45	50
St. Alexis Hosp., Cl.	Church	255	10,270	14	100	8	No	Req	35	50
St. John's Hosp., Cl.	Church	285	8,973	14	100	8	No	None	47	50
St. Luke's Hosp., Cl.	Church	402	12,713	13	72	20	No	Req	49	30
St. Vincent Charity Hosp., Cl.	Church	290	8,338	18	100	12	(188)	Req	41	50
University Hospitals, Cl.	NPA	817	20,121	34	100	30	No	Req	75	—
Grant Hospital, Columbus	NPA	327	10,020	5	100	8	No	None	34	75
Mt. Carmel Hosp., Col.	Church	315	10,172	4	100	10	No	Req	32	50
St. Francis Hosp., Col.	State	161	3,979	—	100	9	No	Req	29	No
Starling-Loving U. Hosp., Col.	State	314	8,360	52	100	16	(190)	None	69	9
White Cross Hosp., Col.	Church	358	10,769	5	85	8	No	Req	46	50
Good Samaritan Hosp., Dayton	Church	381	12,280	4	—	6	No	None	—	50
Miami Valley Hosp., Dayton	NPA	480	13,236	—	—	12	No	Req	42	50
St. Elizabeth Hosp., Dayton	Church	375	11,129	10	—	6	No	Req	22	100
Huron Road Hosp., E. Cleveland	NPA	433	10,655	2	100	15	No	Req	39	50
Mercy Hospital, Hamilton	Church	325	8,234	25	100	6	No	Req	36	50
Lakewood Hospital, Lakewood	City	157	5,411	1	100	4	No	Req	48	50
Lima Memorial Hosp., Lima	NPA	189	6,149	5	75	4	No	None	28	90
St. Rita's Hosp., Lima	Church	300	6,548	—	100	6	No	Req	22	50
Springfield City Hosp., Sp.	City	329	7,103	3	100	6	No	Req.	36	100
Maumee Valley Hosp., Toledo	County	325	3,728	90	100	8	No	Req	43	75
Mercy Hospital, Toledo	Church	340	11,051	25	100	8	(191)	Req	49	75
St. Vincent's Hosp., Toledo	Church	360	10,539	—	—	12	No	Req	48	75
Toledo Hosp., Toledo	NPA	320	9,432	3	100	10	No	Req	55	75
St. Elizabeth Hosp., Youngstown	Church	300	14,946	3	100	10	No	Req	23	100
Youngstown Hospital	NPA	632	18,968	4	100	15	No	Reg	44	25

In the above table NPA stands for non-profit association. Key numbers under the heading "Affiliated Service" indicate the following affiliations: (182) Children's Hospital, Akron; (183) Edwin Shaw Sanatorium; Summit County Receiving Hospital, Cuyahoga Falls; (184) Children's Hospital, Cincinnati; (185) Dunham Hospital; Hamilton County Home and Chronic Disease Hospital; (186) Cincinnati General Hospital; (187) Cincinnati General Hospital; (188) St. Ann's Maternity Hospital, Cleveland; (189) Children's Hospital, Columbus; (190) Children's Hospital; St. Francis Hospital; (191) Maumee Valley Hospital; William W. Roche Memorial Tuberculosis Hospital.

All of the hospitals named offer a rotating internship, which is defined as one which provides supervised experience in internal medicine, surgery, pediatrics, obstetrics and their related subspecialties, together with experience in laboratory and radiologic diagnosis.

All of the internships are for 12 months with the exception of those at University Hospitals, Cleveland, Starling-Loving University Hospital, Columbus, and Youngstown Hospital, which are for 24 months each.

2; internal medicine 4; obstetrics and gynecology 4; orthopedic surgery 3; pathology 1; radiology 3; and surgery 4.

Sunny Acres, Cuyahoga County Tuberculosis Hospital, Cleveland—Pulmonary diseases 6.

St. Vincent Charity Hospital, Cleveland—Internal medicine 3; pathology 1; radiology 2; and surgery 9.

University Hospitals, Cleveland—Dermatology and syphilology 2; internal medicine 23; obstetrics 5; ophthalmology 3; otolaryngology 2; orthopedic surgery 2; pathology 6; pediatrics 7; psychiatry 5; radiology 4; surgery 16; and urology 1.

Woman's Hospital, Cleveland—General residency 2.

Grant Hospital, Columbus—Pathology 1.

Mt. Carmel Hospital, Columbus—Internal medicine 1; orthopedic surgery 1; and surgery 1.

Children's Hospital, Columbus—Orthopedic surgery 2; and pediatrics 13.

Franklin County Tuberculosis Hospital, Columbus—Pulmonary diseases 7.

Columbus State Hospital—Psychiatry 4.

St. Ann's Maternity Hospital, Columbus—Obstetrics 2.

St. Francis Hospital, Columbus—Internal medicine 3; and surgery 3.

Starling-Loving University Hospital, Columbus—Anesthesiology 3; internal medicine 11; obstetrics and gynecology 3; ophthalmology 3;

otolaryngology 1; pathology 3; radiology 3; surgery 17; and urology 2.

White Cross Hospital, Columbus—Internal medicine 3; neurological surgery 1; obstetrics 2; orthopedic surgery 1; pathology 1; and surgery 1.

Miami Valley Hospital, Dayton—Internal medicine 2; obstetrics 1; pathology 1; radiology 1; and surgery 3.

Huron Road Hospital, East Cleveland—Anesthesiology 4; internal medicine 1; obstetrics and gynecology 5; and surgery 6.

Fort Hamilton Hospital, Hamilton—General residency 2.

Mercy Hospital, Hamilton—Surgery 3.

Lakewood Hospital—Anesthesiology 1; internal medicine 2; obstetrics 1; and surgery 3.

Mansfield General Hospital—Anesthesiology 2; and general residency 2.

Maumee Valley Hospital, Toledo—Internal medicine 3; obstetrics and gynecology 2; and surgery 2.

Mercy Hospital, Toledo—Obstetrics and gynecology 1; pathology 1; and surgery 1.

St. Vincent's Hospital, Toledo—Internal medicine 1; obstetrics 2; orthopedic surgery 2; radiology 1; surgery 3; and urology 2.

Toledo Hospital—Internal medicine 3; obstetrics and gynecology 3; and pathology 2.

Harding Sanitarium, Worthington—Psychiatry 3.

St. Elizabeth Hospital, Youngstown—Internal medicine 1; obstetrics and gynecology 2; and surgery 4.

Youngstown Hospital—Internal medicine 2; orthopedic surgery 1; pathology 3; proctology 4; radiology 1; and surgery 3.

Massillon State Hospital—Psychiatry 3.

Veterans Administration Hospitals, Cleveland—Internal medicine 28; pathology 1; psychiatry 7; radiology 4; surgery 18; and urology 1.

Veterans Administration Hospital, Dayton—Internal medicine 10.

Film Catalogue

The Academy-International of Medicine has compiled a revised Catalogue of Professional Motion Picture Films. A copy will be mailed upon request to A.M.A. officials, deans of medical schools, and others in key positions. Copies will be mailed to physicians who request them until the supply is exhausted. Requests should be addressed: Academy-International of Medicine, Dept. of Audio-Visual Aids, 214 W. Sixth St., Topeka, Kan.

Prepare Glossary of Terms Used in Atomic Energy

To better inform the physician, the Council on Physical Medicine of the American Medical Association has prepared a glossary of terms used in atomic energy and nuclear physics.

The introduction to the pamphlet says that "nuclear physics as it develops will have important consequences to the practicing physician. New types of injury may require treatment, new hazards will require prevention and new methods of treatment, diagnosis, and research will be introduced. In attempting to inform himself about recent discoveries the physician is constantly baffled by the new vocabulary, which contains some words too recent or too technical to be found in older or less specialized dictionaries. The present glossary is intended to be helpful in this respect."

The glossary was adopted by the Council on Physical Medicine of the American Medical Association, assisted by a large number of consultants on roentgen rays and radium and on the medical aspects of atomic energy.

The glossary explains such terms as atom, atomic number, chain reaction, cosmic rays, cyclotron, element, energy, isotron, isotopes, neutron, radioactivity, radioactive chain, radon, plutonium, uranium, volt and wavelength.

The pamphlet also contains symbols used in writing nuclear reactions.

Health Fellowships Offered

Fellowships leading to Master's Degrees in public health in the field of health education are again being offered, with funds available through the National Foundation for Infantile Paralysis. The fellowships consist of eight or nine months academic work which begins with the Fall term of 1948. Information may be obtained from the foundation office, 120 Broadway, New York 5, N. Y.

Veterans are encouraged to apply, and will be paid the difference between their subsistence allowance under the G. I. Bill of Rights and the monthly stipend of \$100 for single or \$150 for married veterans.

It's Not Too Early! To Get the Lowdown on Candidates for the State Legislature, Congress and Other Elective Offices. What Are Their Views on Medical and Health Matters? What Are Their Qualifications?

Do You Know? . . .

A study made by the Division of Safety and Hygiene of the State Industrial Commission indicates that 21,985 of the injury cases reported in 1947 developed infection. This represents 7.6 per cent compared with 7.0 per cent in 1946.

* * *

The Versailles Chamber of Commerce recently had an appreciation dinner for the medical profession of the community and in honor of Dr. W. C. Gutermuth who retired June 1 after 54 years in the practice of medicine there.

* * *

Dr. Allan C. Barnes, Columbus, professor and chairman of the department of obstetrics and gynecology, Ohio State University College of Medicine, was one of the guest speakers at the annual meeting of the North Dakota State Medical Association, May 22-25, at Jamestown, N. D. He discussed: "Use of Female Sex Hormones in Clinical Practice."

* * *

The Clark County Medical Society is presenting the A.M.A. transcribed program "Fair and Cooler" over radio stations WJEL and WJEM—FM, Springfield, each Saturday afternoon at 1:45 p.m., over a 13-week period.

* * *

Col. Harry G. Armstrong, commandant, Air University School of Aviation Medicine, Randolph Field, Texas, has been promoted to the rank of brigadier-general. Gen. Armstrong was located at Wright Field, Dayton, prior to World War II, and during the war was surgeon of the 8th Air Force in the E. T. O.

* * *

Ohio had an all-time record crop of babies in 1947, according to the State Department of Health. The total was 197,297, more than 27,000 more than in 1946—the previous high year.

* * *

Dr. Richard L. Meiling, Columbus, secretary of the Council on National Emergency Medical Service of the American Medical Association, discussed the functions of that council before a conference of the American Pharmaceutical Association in Washington on May 6. Dr. Meiling also is a member of the Ohio State Medical Association's committee on National Emergency Medical Service.

* * *

The department of preventive medicine of Western Reserve University School of Medicine has received a grant of \$15,000 from the Frederic M. and Nettie E. Backus Memorial Fund of the Cleveland Foundation, to assist in a 10-year study of the spread of common infections.

Dr. P. L. Harris has resigned as chief of the division of communicable diseases of the State Department of Health, to become health commissioner of Stark County.

* * *

Dr. Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, has accepted a five-week teaching assignment in the Far East for the Surgeon General of the U. S. Army.

* * *

The new president of the Ohio Student Health Association is Dr. E. Herndon Hudson, Athens, director of the student health service of Ohio University.

* * *

According to Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company, there were about 3,000,000 people in the United States at ages 65 or over in 1900; by 1940 the number in this age group had increased to 9,000,000. He estimates that their total will be 14,000,000 by 1960 and 21,500,000 at the close of the century.

* * *

Dr. Edward J. Humphreys, Columbus, acting state commissioner of mental hygiene, is the new president of the American Association on Mental Deficiency.

* * *

A student nurse from each of the 10 nursing schools of Greater Cleveland was given a \$25 award by the Woman's Auxiliary to the Cleveland Academy of Medicine. In granting the awards, progress, faithfulness and personality were rated above academic accomplishment.

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Dr. Harry Wain, acting director and business manager of Miami Valley Hospital, Dayton, has been appointed health commissioner of Mansfield and Richland County. For several years Dr. Wain was health commissioner of Miami County.

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The latest addition to newspaper comic strips "Rex Morgan, M.D." is in at least two Ohio newspapers, the *Cleveland Plain Dealer* and the *Columbus Citizen*.

* * *

Dr. H. V. Dutrow, Dayton, is one of the Republican nominees for the Ohio House of Representatives from Montgomery County.

* * *

Dr. Jonathan Forman, Columbus, is the new president of the Ohio Valley Society of Allergists.

O. S. U. Medical Center . . .

Ground Breaking Ceremonies Open Construction in Columbus On \$11,000,000 Medical Center at Ohio State University

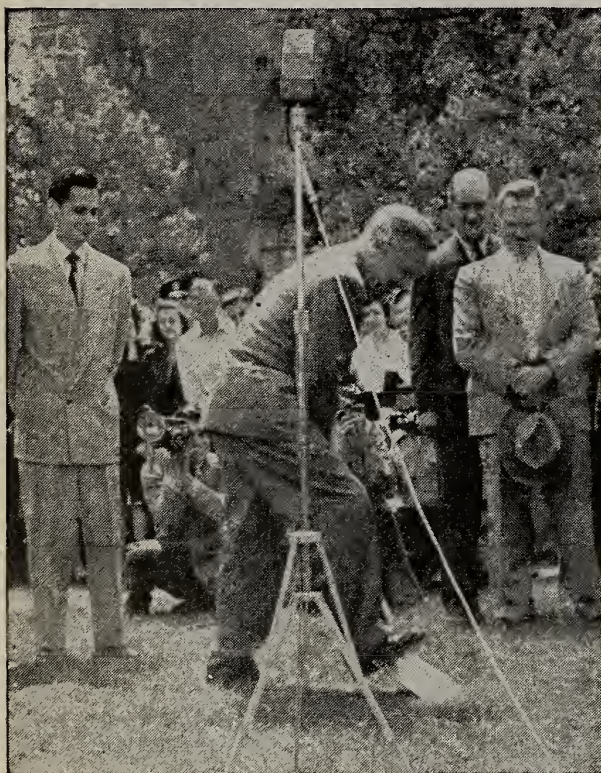
CONSTRUCTION of Ohio State University's \$8,000,000 medical center is now well underway after University officials broke ground on the Columbus campus on May 13. Construction is expected to continue until early 1950.

Buildings now under construction are the main 11-story, 600-bed main teaching hospital and the three-story dental college building. Wings for which plans are nearing completion are the \$2,000,000, 300-bed tuberculosis hospital for the Ohio Department of Health, and the \$1,200,000, 200-bed neuropsychiatric receiving hospital for mental patients of the Ohio Department of Welfare.

Plans call for using the present University

officials point out that if the Federal Government decides to place a veterans' hospital in the center, it will become the largest hospital in the United States.

At ground breaking ceremonies on May 13, Dr. Charles A. Doan, dean of the College of Medicine,



O. S. M. A. Staff Photos.

Dean of Medicine Charles A. Doan breaks ground. At left, is Stanley Jacob, who presented the silver spade in behalf of the senior medical class. At right in foreground is Dr. H. M. Clodfelter, Tenth District Councilor and President of the Columbus Academy of Medicine.

Hospital building as a student medical center with 90 infirmery beds, and to house medical research and administrative activities.

The new construction will make the University Hospital the largest hospital in Ohio, and of-



"We will have one of the finest medical centers in the world," Governor Thomas J. Herbert told the gathering. On the platform with the Governor is University President Howard L. Bevis.

received a silver spade, which Stanley Jacob, senior in the College of Medicine, presented in the name of his class.

Dean Herbert S. Atkinson, chairman of the Board of Trustees, Dr. Doan and Dean of Dentistry Wendell D. Postle, took turns in breaking ground.

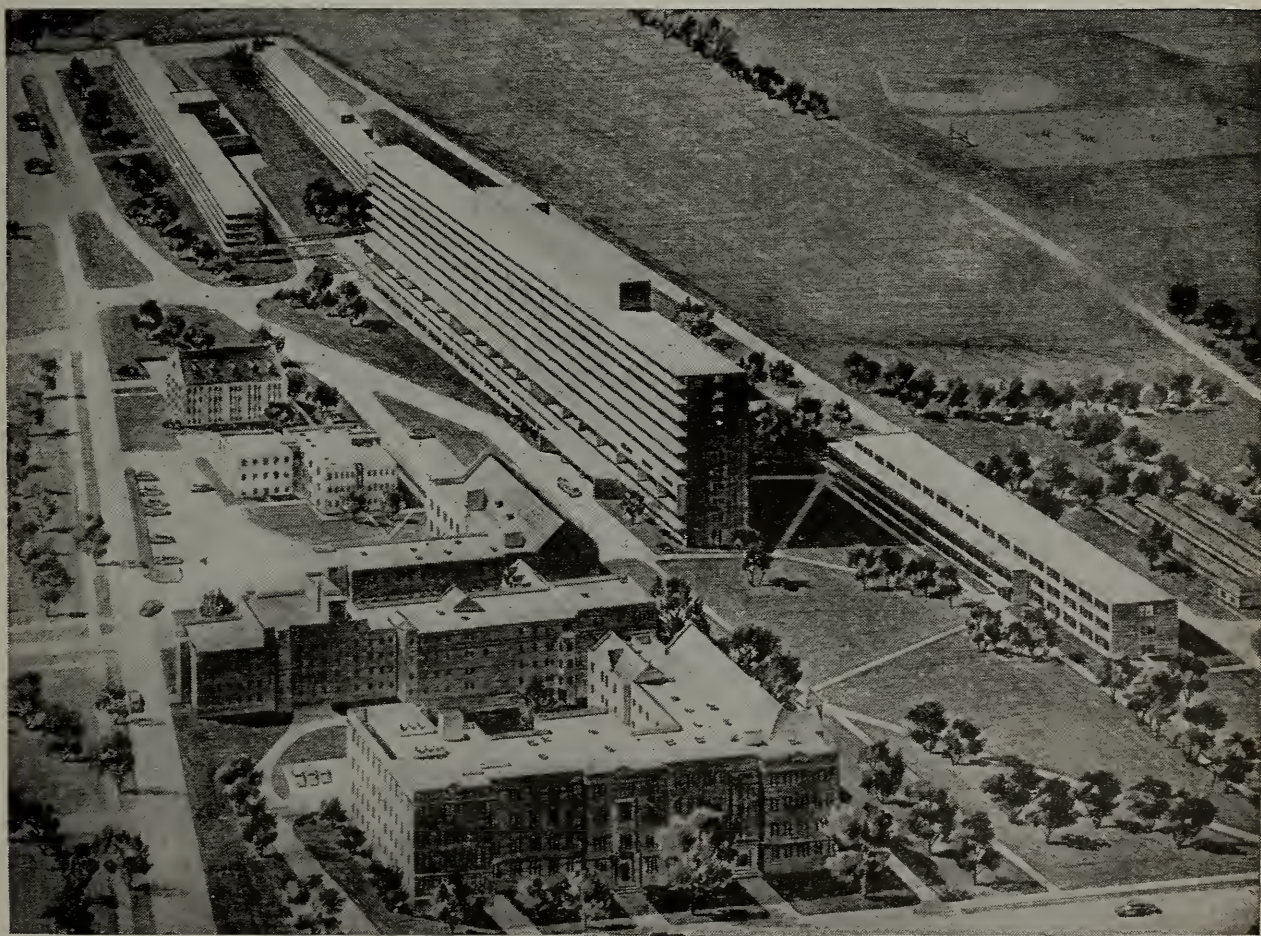
"When this work is completed," Governor Thomas J. Herbert said at the ceremony, "we will have one of the finest medical centers in the world to bring further luster to Ohio State."

Special gratitude to Dr. Russel Means, "whose actions in this behalf have been most helpful and effective," was expressed by University President Howard L. Bevis.

O. S. U. Medical Center—Now and in 1950



This is the site of the new medical center, showing excavation work well underway early in June.



Above is the Ohio State University Medical Center as the architects picture it upon completion. In the center is the main 11-story teaching hospital, with the dental college building to the right. The wing to the left in background is the proposed tuberculosis hospital, with the proposed receiving hospital for mental patients to the right. Buildings in the foreground are the present Hamilton Hall and University Hospital.

Photo by O. S. U. Dept. of Photography

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

A CRITICAL LOOK AT THE V. A. EXPANSION PROGRAM

Distinguished Columbus civic leaders have formed a committee to promote the construction of a new 600-bed Veterans Administration hospital adjacent to the Ohio State University Medical Center where it can be operated in conjunction with the center and the Ohio State University College of Medicine.

In a brochure prepared by the committee strong arguments are advanced in favor of the proposal. It is pointed out that erection of the V. A. hospital near the medical center will insure services of the highest quality because the activities of the hospital can be correlated with the teaching and research work of the medical school and specialized services can be obtained from members of the faculty.

There is no disagreement with the policy of the V. A. to coordinate its hospitals with medical teaching centers, thus assuring excellent medical services by an adequate number of skilled physicians for specialized and consultation services.

If the V. A. decides to build another hospital in Ohio, in our opinion a spot adjacent to the medical center in Columbus is the place for it.

However, before ground is broken in Columbus—in fact, in any locality—for a new V. A. hospital, some pertinent and basic questions regarding the entire Veterans Administration building program should be raised—and answered. For example:

Is another Veterans Administration hospital needed in Ohio?

Is another Veterans Administration hospital needed any place?

If, as the V. A. and others contend, additional V. A. hospitals are needed, how do they justify the fact that more than half of the beds of existing V. A. hospitals are now occupied by veterans with non-service-connected disabilities?

Should veterans without service-connected disabilities be hospitalized at government expense even though they are economically able to provide hospitalization for themselves?

If more hospital beds are needed for the civilian population generally, both pay and no-pay patients, veterans and non-veterans, is it the function of the Federal Government, through the V. A. or any other Federal agency, to build and operate such hospitals?

In other words, how far should the Federal Government go in providing medical and hos-

pital services to persons other than veterans with service-connected disabilities?

When and if there are not enough veterans with service-connected disabilities to keep all of the present and contemplated new beds in veterans hospitals occupied, who will be admitted to these institutions? Under what conditions? At whose expense?

Is the plan to throw open present and new veterans hospitals to all veterans and members of their families, regardless of their economic status? To those who are not veterans?

When and if there is a surplus of beds for service-connected veterans will the Federal Government abandon hospitals no longer needed or will it continue to operate a medical-hospital program for civilians at large?

Is any Ohio veteran with service-connected disabilities unable to obtain hospital care at the present time?

How many of the 200,000 veterans in Central and Southeastern Ohio who, it is said, are without veterans hospital services, are, or should be, eligible for medical and hospital care at the expense of the Federal Government?

Should the Veterans Administration medical-hospital program be used to finance teaching and research centers or should legislation which can stand on its own feet be enacted to provide Federal aid for such purposes if such financial aid is needed?

If a new V. A. hospital is erected in Ohio will the V. A. close some of its older facilities which are now occupied by a large number of veterans with non-service-connected disabilities?

These questions are asked not with the idea of putting obstacles in the way of the Veterans Administration in its efforts to provide disabled veterans with the best kind of medical care. We endorse that policy one hundred per cent.

Neither are we opposed to efforts to make the Ohio State University Medical Center one of the best and biggest in the country. We have been an exponent of that and will continue to be.

Nevertheless, the time has arrived when the implications of the expansion program of the Veterans Administration should be understood by the medical profession and taxpayers generally, including veterans themselves.

The basic issue is not: Should a V. A. hospital be built at the Ohio State University Medical Center?

The all-important question is: How long should the Federal Government continue to erect Federal

hospitals, for the V. A. or any other agency, where medical and hospital care for a substantial portion of the population eventually will be provided, with the Federal Government running the institution and footing the bills from money collected from taxpayers? How will such a program, if carried to its ultimate possibilities, differ from some of the medical care programs proposed in such pieces of legislation as the Wagner-Murray-Dingell bills, and their like?

That's the basic issue.

The enthusiast may say: Congress already has appropriated one billion dollars for new V. A. construction, so Ohio—Columbus—might just as well get its cut. That is phoney logic—if logic. The money has been appropriated. So what? If it isn't spent, it will be saved. It should be spent only when the need for spending it is proven—when the need for more beds for veterans with service-connected disabilities is proven.

What can the reader who may agree with the above do about the matter? Well, he might talk it over with his Congressman. His Congressman may regard it as a rather unpleasant and uncomfortable subject for conversation—for obvious reasons. Nevertheless, someone is going to have to ask for a showdown unless, of course, nobody gives a hang about where the parade is going and why.

These observations are not going to be received joyfully by quite a number of very sincere and very substantial people who, perhaps, have not analyzed the whole question with its far-reaching implications. Nevertheless, this to the contrary notwithstanding, it's necessary to call a spade a spade.

NEWSPAPER EDITOR LOOKS AT THE LOCAL MEDICAL SOCIETY

It would be a swell idea if every County Medical Society would invite the editor of the local newspaper to a couple of meetings of the society each year.

The Lorain County Medical Society did. Here, in part, is what he wrote about his visit:

"Last evening the editor of the *Chronicle-Telegram* attended a meeting of the Lorain County Medical Society. Of course the subject discussed was over our head. We do not understand medical terms as we have never studied medicine. We did get one thing out of the meeting, however, and that is that the physicians who serve us here in Elyria and Lorain County are sincere professional men. They are meeting periodically to hear experts discuss various 'diseases'. They are keeping up with new methods and new medicines by having these meetings which are addressed by men who stand high in their special fields of medicine and surgery.

"We found out last night that the members of medical profession are deeply interested in their work. They do not know anything about a 40- or a 48-hour week. They work far into the night as the occasion demands. New drugs and

new methods are constantly changing medical practice and the physician has to keep up with the improvements. Not only does he have to work long hours looking after his patients but he has to find time to read and to study for if he fails to do so he will find that the parade of medical progress has passed him.

"It was a pleasure to spend a couple of hours with the physicians and surgeons of Lorain County last evening and their sincerity and earnestness made an impression on us."

The next time the representatives of that society go to that editor to talk over sundry matters, they are quite likely to find him receptive to hearing their views and to cooperating with them if at all possible.

WARNING TO PHYSICIANS ON PRESCRIBING FOR VETERANS

Apparently some physicians misunderstand the provisions of the Veterans Administration plan whereby physicians authorized to treat veterans with service-connected disabilities may write a prescription, if indicated, for the veteran to have filled by a pharmacist who is paid by the V. A. under an agreement between the Ohio State Pharmaceutical Association and the V. A.

The V. A. and some druggists have complained that some physicians are writing prescriptions for veterans, indicating on the prescription they are authorized "to treat and prescribe for the above-named Veterans Administration patient" when such is not the case.

Under the V. A. regulations it is not obligated to pay a druggist for a prescription filled unless the physician writing the prescription has been authorized by the V. A. to treat the veteran. Even authority to examine a veteran does not carry with it authority to treat and prescribe for the veteran. Specific authority to treat a veteran must be obtained, in which case authority to prescribe is implied.

As a result, some druggists have had to take a financial loss as the pharmacist has filled the prescription in good faith, finding out later that the physician had no authority to prescribe for the veteran.

This practice not only jeopardizes the relationship between the medical and pharmacy professions but also constitutes a technical violation of Federal statutes, if the physician knowingly or willfully prescribes for a veteran when he is not authorized to treat him.

Doubtless, the cases cited have resulted from misunderstanding on the part of the physician and are not willful violations of the regulations. Regardless, physicians must be careful to comply with the regulations. Those who do not may find themselves in an embarrassing situation.

Incidentally, the V. A. prescription program is no small potatoes. For the period October, 1946, through May, 1948, prescriptions processed

totaled 45,657 prescriptions and \$109,853.01 was dispersed to druggists.

Speaking of "abuses" on the part of physicians in connection with V. A. activities, Dr. Paul Magnuson, chief V. A. medical officer, is reported to have announced that 28 cases of unethical practices or fraud have been uncovered in the recent investigation made by the V. A.

Obviously, the guilty physicians should be disciplined or prosecuted. However, the number of cases is indeed small as about 87,000 doctors are participating in the program. All of which supports our previous contention that Dr. Magnuson spoke a wee bit hastily and out-of-turn some months ago when he issued a public statement implying widespread abuses and shady practices by physicians.

QUESTIONABLE PUBLICITY ON MEDICAL EDUCATION

In a recent statement published by Ohio newspapers, Junior Dean William S. Guthrie of the College of Arts and Sciences, Ohio State University, is reported to have charged that medical schools have failed to make provisions to train more physicians and implied that no efforts are being made to increase the facilities for training of additional physicians.

None will disagree with Dean Guthrie's statement that there is a great need for additional physicians and that it is difficult to explain to students, and the public, why there is no room in the medical schools for all of those who desire to make medicine a career.

In our opinion, it is unfortunate that Dean Guthrie saw fit to add to the confusion by issuing a statement which gave the press an opportunity to give the public but one side of the story. In fact, conferences participated in by those who are well-informed and who desire to increase the supply of physicians, but physicians who are well-trained, not half-trained, will be far more valuable in solving the problem than publicity, especially lop-sided publicity.

Actually, during the five-year period, July 1, 1942, to June 30, 1947, medical school graduates totalled 32,877, compared to 25,818 graduates in the preceding five-year period, or an increase of 27.3 per cent. In fact the supply of physicians has increased at a relatively more rapid rate than the population as a whole. That the armed forces took some of these graduates is something which needs explaining also.

During 1947, one new medical school was added to the approved list; one new medical school opened; and plans for new schools or expansion of present schools are being pushed in many states, including California, North Carolina, North Dakota, Missouri, and Florida.

Other matters which Dean Guthrie's report did not mention include the following:

What, if any, efforts are being made by the colleges of arts and sciences to discuss the problem with students planning to enter premedical training; to frankly warn them, early, of the stiff competition which confronts those applying for admission to medical schools?

What, if any, efforts are being made by the colleges of arts and sciences to encourage students planning a medical career to seriously consider establishing themselves in small or rural areas after completing their training?

What, if any, efforts are being made while the student is in premedics to encourage him to enter general practice—an opportune time to create correct thinking along these lines?

What, if any, efforts, are being made to explain to dissatisfied students—or others—that it costs a lot of money to establish and operate a medical school; that such schools are not created overnight; that even existing schools are confronted with financial problems; that sub-standard schools will be worse than none at all?

Admittedly, the problem exists—and solutions must be found. Nevertheless, ill-advised and incomplete publicity will not be helpful—merely add confusion to confusion.

LOCAL COMMITTEES CAN BE REAL P. R. AGENTS

Each year the Ohio State Medical Association requests its component county medical societies to appoint a certain number of committees to work with the State Association's committees, to assist in coordinating state and local activities, and to carry on local programs of importance to the medical profession.

Each year, when this request goes out, some local officer can be counted on to write into the Columbus Office, inquiring why it is necessary to appoint so many committees; why it is necessary to name some particular committee; or, perhaps, why have any committees at all.

There may be many good reasons but we think the one offered by Dr. Creighton Barker, secretary of the Connecticut State Medical Society, is sufficient.

In a recent talk on public relations, Dr. Barker made these suggestions for effective ways to produce favorable public opinion:

"With alert planning and consistent effort our societies can place useful members on the boards of directors of the private agencies and accomplish three desirable ends. First, the agencies are materially helped by capable medical guidance; next, the ideals and policies of medicine can be introduced into the operations of such agencies which, when left to themselves, occasionally have peculiar ideas, and, finally, the medical society, through its representatives, is brought into continuous contact with citizens

who are likely to be important civic and social leaders. I have seen this plan work so well that, coupled with constructive aid to state government, I believe it to be the most substantial way for developing good public opinion and confidence."

A substantial part of the time of some of the state committees and the state office personnel is devoted to the work cited by Dr. Barker.

If the same is to be done locally—and it should—then committees must be organized and representatives named to cooperate and work with the non-medical groups in the community.

THIS IS GOOD PUBLIC RELATIONS IN ACTION

In a recent issue of the *Perrysburg Journal*, there appeared a letter from the Board of Education, reading in part as follows:

"The Board of Education of Perrysburg extends its sincere appreciation to the medical men of the village who gave so freely and generously of their professional attention to the pre-school pupils during the school clinics held recently. Without the assistance of Doctors James J. Bayer, James R. McAuley, Paul F. Orr, and L. S. Pugh, the school district could never have realized the benefits derived from the clinics."

In our opinion, the physicians named also made a real contribution to the public relations of the medical profession.

Unfortunately, there are some physicians who haven't learned as yet that good will and public esteem are intangible benefits which are far more valuable in many instances than additions to their bank accounts.

IF YOU HAVE EVIDENCE, SEND IT IN

The Council of the State Association intends to file a protest with the Veterans Administration and others relative to the use of the outpatient and hospitalization facilities of the V.A. by veterans who are not suffering from service-connected disabilities and who are financially able to pay for medical and hospital care.

Naturally, sound evidence will be necessary. Some evidence has been assembled. Additional evidence will be welcomed.

Physicians who can supply information to substantiate this charge should send it to the Columbus Office of the State Association.

RULE BY A MINORITY CANNOT BE TOLERATED

The scuttlebutt is that a group of radical, leftist physicians, many of them members of the Physicians' Forum, tried to take over control of the Medical Society of the County of New York at the recent annual election of the society. Out of 3,287 votes cast, the slate of radical candidates received 1,204 votes. Some

of the candidates are Communists and the slate was backed by physicians friendly to the fellow travelers, it is reported.

As one commentator said: "When Communists get 38 per cent of a vote among doctors, it's time to wake up."

In fact, this is not the time when any physician dares to take only an apathetic or casual interest in the activities of his medical society, hospital staff organization, or any other group which has anything to say about the practice of medicine and medical economics.

We don't believe any county medical society in Ohio is going to be taken over by Communists. Nevertheless, it would be a good idea for each physician to get in and pitch on county society activities. That is the way for him to express his views and to take a personal interest in making his society an effective organization in the interest of not only the medical profession but the community as a whole.

"YOU CAN DO PLENTY ABOUT POLITICS"

No sir, it's not too early for the medical profession to start thinking about that important date, Tuesday, November 2, when all citizens who care anything about themselves and their communities will go to the polls to elect public officials.

Now is the time for Ohio physicians to start getting information about the candidates from whom final selections will be made. Unless the voter knows pertinent things about the candidates he can hardly vote intelligently.

To those who may say: "Politics is not for us," we recommend the following editorial from *Kiplinger Magazine*, the content of which is just as applicable to physicians as to businessmen:

BUSINESS AND POLITICS DO MIX

Businessmen give me a pain when they look down their noses at politics and politicians, when they toss off smug remarks about how "politics is just a racket," when they say that "business and politics don't mix." Such people who say this are living in a dream world, not facing the facts of life.

One fact is that business and politics have been twisted together like strands of a rope since long before this nation was established. They are intertwined now and always will be. It is as silly to pretend that politics is none of your business as to pretend that the weather is none of your business. The difference is that you cannot do anything about the weather, and you can do plenty about politics.

First, you can watch how the political winds are blowing. Politics shows the trend of public opinion, and public opinion has a thousand ways of affecting business.

Laws and the administration of laws are made by the processes of politics, and laws can help or hurt a business, sometimes even make or break a business. Most proposed laws originate in

some segments of the people, and are merely sponsored by the politicians. Sure, there's politics behind them, but it may be business politics. Some movements may seem to you to be rackets, but you don't bust up rackets by sighing and saying "tut tut."

You can shrug your shoulders, if you wish, and take no part in politics, but if you do this, then you are on the outside, looking in, perhaps crying about it.

Should you try to influence politics? Yes, of course. You are a citizen, aren't you? Should you line up back of lobbies and pressure groups? Sure. The lobbies and pressure groups are much maligned, but they perform a useful function. They mobilize segments of public opinion. Farmers used them and got to the top of the political heap. Labor unions used them, and made themselves into the No. 1 political power. But some businessmen are lofty and disdainful of the grubbiness of politics, and so they have lost political influence.

You play politics within your business. You play politics with your customers. You try to get your product "re-elected" by your customers. If you can't extend your interest to the sphere of "political politics," then you have no license to yammer when things don't go the way you wish.

ACCORDING TO THE NEWSPAPERS

Henry P. David, graduate student in clinical psychology, according to the *Columbus Citizen*, told the Ohio Academy of Science, that many of the so-called psychologists, offering to counsel folks on everything from marriage to getting a job, are nothing more nor less than quacks of the mail-order variety.

* * *

C. K. Rockwell of the *Wapakoneta Daily News* after reading the "In Our Opinion" in the June issue commending him for some observations he made recently, opines that he will "be a trifle more cautious in our remarks along this line now that we are aware of the fact that we may have to eat them sometimes", proving that it is good for both editors and doctors to get together for chitchats at which mutual understandings can be arrived.

* * *

Not that we want to be accused of preaching but we can't resist the opportunity to point out how the public feels about medical morals and ethics, as exemplified in the following excerpt from the editorial columns of the *Dayton Herald* which makes a lot of sense:

"Doctors, along with ministers and lawyers, hold a peculiar place in society. Generally, the person who goes to them for solace or aid, places himself completely in their confidence. Because of his lack of technical knowledge, the patient must rely upon the doctor's character and skill.

"For this reason, it behooves the men of medicine to maintain the highest standards. Fortunately, the sharpers and incompetents are

few, but unless their own colleagues control or expose them, the State may be forced to do a much cruder and less expert operation—and without an anesthetic."

* * *

According to the Associated Press out of Boston, C. I. O. President Philip Murray has indicated that union negotiations in the steel industry have shifted from wage demands to health, welfare, and pension plans, meaning that union-management huddles from now on will be of direct interest to the medical profession.

* * *

As reported in the *Akron Beacon-Journal*, an example of "morbid curiosity" about health is the enormous interest on the part of the public, especially 'teen agers, in Kinsey's "Sexual Behavior in the Human Male," Dr. Millard C. Beyer, chairman of the Medical Education Committee of the Summit County Medical Society, stated in an address to the Akron Advertising Club, in which he also pointed out that material meant only for physicians ought to remain just that.

* * *

Looks as if the British physicians have now decided to go along with the government on its slightly modified medical-care-for-all program. In fact, some badly hashed-up publicity on the so-called "Battle of Britain" has been given to the American people—and doctors, through literature issued by certain organizations. The battle was not against State Medicine. England has had that since World War No. 1 days. The scrap was over certain new provisions, those making doctors serve where the Government wanted them to serve, banning the sale of practices, making all physicians serve on a salary, etc. Which boils down to the fact that you can't have your cake and eat it. Or, to put it another way, whenever a system of State Medicine gets a good start, as it did in Britain, be prepared to expect the worst—eventually.

* * *

We see by the papers that the County Commissioners and the Medical Society of Trumbull County have entered into an agreement for the care of the county's indigent sick, calling for basic fees and reviewing committees. Also, the Mahoning County Medical Society has set up a foundation to receive funds available for care by physicians of hospitalized indigents, such money to be used for educational and research activities for the benefit of all members of the medical staffs of the Youngstown hospitals, premedical students at Youngstown College, and nurses. We recommend that some sound thinking and action like the above be done in other counties. At least relief officials and medical society representatives should sit down and talk

over the question. It's surprising how quickly problems can be settled across the conference table.

* * *

Commenting on the shortage of doctors in some areas, these words of wisdom were published in the *Circleville Herald*—other papers please copy:

"For the long term future, the community without a doctor might do well to find some promising and community-loyal youth in its own younger set, and send him to medical school, hoping he may return one day to become the community physician.

"Making life attractive to the young physician and his family by paying his bills promptly would help a good deal, too. Doctors and their families have to eat and buy clothes and other things. Some people are apt to forget this."

AN OBJECT LESSON FOR SOME JUDGES

In sentencing a chiropractor who had been a habitual violator of the Medical Practice Act, Municipal Judge Frank M. Gusweiler, Cincinnati, advised the offender that he had had ample opportunity to comply with the law and "I won't stand for any citizen to hold the law in contempt." Judge Gusweiler also stated that if persons were permitted to willfully violate the law merely because they did not approve it, "this would end up in anarchy and a complete disregard for government and law and order."

Judge Gusweiler is to be commended for his firm stand and judicious attitude.

Some occupants of the bench can learn a lesson from his views. Until they do, widespread contempt for the law—any law—will prevail.

CONSERVATION MOVEMENT OFFERS REAL LESSON

O. E. Baker, recognized as the leading rural sociologist of the country, has pointed out that the reason we have such a great conservation movement today is because "so many minds are conditioned."

This conditioning came about through what J. Russell Smith succeeded in doing back in 1905 when he was helping Pinchot and Teddy Roosevelt, namely, getting material on conservation written into the geographies used in our public schools.

It took 30 years—1905 to 1935—to get the Soil Conservation Service set up by law and 10 years to get almost general acceptance of the valid character of its objectives. It probably will take 15 years more to get the job done.

Why are these facts important to the medical profession?

Simply because they illustrate that what our school children are being taught about health and how to keep it, sickness and how to prevent it or take care of it, will determine more than anything else the position of American Medicine and American Health 30 years from now.

The Committee on School Health of the Ohio State Medical Association and those which will be set up in each county face a real challenge. Moreover they will have the greatest opportunity of almost any committee in the Association to protect the people against plans not within the American framework.

Think it over. If your County Medical Society does not have a committee on school health, see that it does. This is going to be a field of real action—and soon.

HOW-CAN-WE-GET-A-DOCTOR QUESTION ANALYZED

An interesting check on how well physicians answer emergency calls has been made by the Cleveland Academy of Medicine which maintains a call bureau. It was found that the bureau dispatches a physician to a sick call within 8.7 minutes from the time the call is received; that most emergency calls are received from 6:00 p. m. to 8:00 a. m.; and that 300 emergency calls reviewed were answered by 77 different physicians.

Obviously, this good situation may not prevail in areas where call service facilities are not available. Nevertheless, the data show a trend, namely, that most physicians don't play fast and loose with sick calls and that in most cases where there is delay, the physician has a logical excuse.

Speaking of the cry "How can we get a doctor to make home visits?" raised by residents in some rural areas, we heard a speaker not long ago before a rural group who handed out some good advice on this question.

He pointed out that some farm families would not have the trouble they have in getting a doctor, especially at night, if they would establish a firm family-physician relationship with a doctor in the community. When this is done, the physician is more likely to make a special effort to respond at any hour.

Also, the speaker advised farm folks not too far from medical centers to give the home-community doctor a better break by seeing him before they rush off to the city for medical care. When the local physician finds that folks are consulting the city physician for services which he is equipped to render, he is not going to get too excited when he is called as an afterthought or just in so-called emergencies.

When the question is boiled down, of course, almost any physician is going to respond to emergency calls. But, he is going to be a bit more enthusiastic about it if he regards the family as "one of my families" and knows that the family is going to come to him for advice in the first instance, instead of shoving off for the city at every whipstitch.

In Memoriam . . .

John William Harmon Beach, M. D., Arlington (Hancock County); Fort Wayne College of Medicine, 1898; age 75; died May 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Beach practiced medicine in Arlington and vicinity for more than 50 years. He served as a major in the Army Medical Corps during World War I, was a member of the Lutheran Church, several Masonic orders, and the American Legion. Survivors include his widow, two daughters, four sisters and two brothers, one of whom is Dr. H. C. A. Beach of Columbus.

Raymond Bernard Benning, M. D., Fort Recovery; Northwestern University Medical School, 1936; age 38; died May 21; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Mercer County Medical Society in 1943 and a delegate of that society to the O. S. M. A. in 1941. Dr. Benning practiced medicine in Fort Recovery for 12 years. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his parents, five brothers and four sisters.

James Richard Brandon, M. D., Canton; Ohio State University College of Medicine, 1925; aged 51; died May 29; member of the Ohio State Medical Association and a Fellow of the American Medical Association; a fellow of the American Academy of Ophthalmology and Otolaryngology and a diplomate of the American Board of Otolaryngology. He was a member of the Presbyterian Church, the Canton Club, Congress Lake Club and the Masonic Lodge. Surviving are his widow and a son.

Herman Bryan, M. D., Wooster; University of Pennsylvania School of Medicine, 1901; aged 73; died May 9. Dr. Bryan was appointed by the Presbyterian Board of Foreign Missions in 1902 as a medical missionary to China. During World War I he served in the Army Medical Corps. He also is a veteran of the Spanish American War. He was taken prisoner by the Japanese early in World War II and was repatriated to this country in 1942. Surviving are his widow, a son and a daughter.

Harry R. Carroll, M. D., Cincinnati; University of Cincinnati College of Medicine, 1912; aged 58; died May 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Carroll was a veteran of World War I. He was a member of the Cuvier Press Club, Xavier Alumni Association and American Legion. He is survived by one sister.

John Raymond Crum, M. D., Stanwood, Iowa; Bennett College of Eclectic Medicine and Surgery, Chicago, 1908; aged 62; died May 8; member of the Iowa State Medical Association and a Fellow of the American Medical Association. Dr. Crum formerly practiced medicine in Forest, Ohio. Surviving are a son, Dr. John D. Crum of Hollywood, Calif., a brother and two sisters.

Percy Edwin Decatur, M. D., Ashland; Eclectic Medical College, Cincinnati, 1904; aged 73 died May 30; member of the Ohio State Medical Association and the American Medical Association, and held membership respectively in the Fayette, Hardin, Butler and Ashland County medical societies. He was vice-president of the Hardin County Medical Society in 1923 and president in 1927; was secretary-treasurer of the Butler County Medical Society in 1930 and president in 1931. He practiced medicine in Ashland for the past 17 years. Dr. Decatur was a member of the Medical Corps during World War I. He was a member of the Methodist Church, the Masonic Lodge and the American Legion. Surviving are his widow, a son, a daughter and a brother.

John Francis, M. D., Hamilton; Miami Medical College, Cincinnati, 1889; aged 86; died May 25; former member of the Ohio State Medical Association and Fellow of the American Medical Association through 1946. Dr. Francis practiced medicine in Hamilton for more than 50 years.

Maude Ruhl Hill, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1894; aged 76; died May 18; former member of the Ohio State Medical Association and the American Medical Association through 1945. Dr. Hill practiced medicine in Cincinnati for 54 years. She was a member of the Medical Women's Club. Surviving is one son.

Allen Webb Hobby, M. D., Sidney; Eclectic Medical College, Cincinnati, 1899; aged 71; died May 31; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1941; president of the Shelby County Medical Society in 1921 and vice-president in 1930. He was a charter member and past-president of the Kiwanis Club, member of the Sidney public school board, a trustee in the Presbyterian Church, and was active in several Masonic orders. Surviving are his widow, and a daughter.

Perry Firestone King, M. D., Alliance; Western Reserve University School of Medicine, 1904;

“...such as Metamucil...”*

For the treatment of the spastic colon the author suggests diet, elimination of the nervous element and “bulk producers.” As examples of these he lists “agar-agar, in finely powdered form, in flakes, or in cereal-like form; derivatives of psyllium seed, such as Metamucil”*

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*Glaske, W. H.: *Spastic Colon*, *M. Clin. North America* 26:805 (May) 1942.

†Council on Pharmacy and Chemistry: *New and Nonofficial Remedies*, 1947, Philadelphia, J. P. Lippincott Company, 1947, p. 320.

aged 70; died May 16; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Stark County Medical Society in 1920 and a delegate to the O. S. M. A. in 1920 and 1933. Dr. King practiced medicine in Alliance since 1906 and was chief of surgery at Alliance City Hospital for many years. He was a trustee in the Mount Union College and was active in athletic and health organizations at the institution. He was a member of the Methodist Church, the Wranglers Club, Alpha Tau Omega fraternity, the Elks Lodge, and a former member of the Alliance Rotary Club. Surviving are his widow, a son, Dr. Robert G. King, also of Alliance, and a sister.

James T. Loomis, M. D., Long Beach, Calif.; College of Medicine and Surgery (Ph. M.), Chicago, 1896; aged 87; died May 24; Dr. Loomis formerly practiced medicine in Fostoria, Wood County, and Toledo before moving to California in 1920. Surviving are two sons and a daughter.

Willard Grant McDade, M. D., East Liverpool; Ohio Medical University, Columbus, 1905; aged 75; died May 8. He was a member of the Presbyterian Church and the Masonic Lodge. Surviving are his widow and a step-daughter.

William H. Orwick, M. D., Massillon, Western Reserve University School of Medicine, 1946; aged 27; died Feb. 20 at Walter Reed Hospital, while serving in the Army Medical Corps.

Daniel J. Price, M. D., Columbus; Starling Medical College, Columbus, 1904; aged 71; died May 8; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947; member of the American College of Surgeons. Dr. Price practiced medicine in Columbus for 24 years and formerly practiced in Newark. Surviving are his widow, three brothers, including Dr. D. R. Price of New Straitsville, and a sister.

John Augustus Riebel, M. D., Columbus; Ohio Medical University, Columbus, 1901; aged 78; died May 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Riebel practiced medicine in Columbus from 1901 until his retirement several years ago. He has been commended for his work during the smallpox epidemic of 1903-04. Fraternal activities included membership in Alpha Kappa Kappa Medical Fraternity and a 50-year membership in the Masonic Lodge. Surviving are his widow, two sons, Dr. Frank A. Riebel of Columbus, and Dr. John A. Riebel, Jr., of Ashland; two brothers including Dr. George P. Riebel of Ashland, and a stepson.

George Walter Sapp, M. D., Newark; Ohio State University College of Medicine, 1911; aged 62; died May 23; member of the Ohio State Med-

ical Association and the American Medical Association; vice-president of the Licking County Medical Society in 1932, president in 1933, and chairman of the society's legislative committee from 1939 through 1941. Dr. Sapp practiced medicine in Newark for 37 years and was Licking County coroner for the past 12 years. He was active in several Masonic orders and was a member of the Moundbuilders Country Club. Surviving are his widow and a sister.

August Henry Schade, M. D., Toledo; Toledo Medical College, 1908; aged 63; died May 15; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Society of Clinical Pathologists. Dr. Schade was pathologist at Robinwood Hospital since 1920. He was in the Army Medical Corps during World War I, was a member of the American Legion, past-president of the Toledo Kiwanis Club and a member of the Elks Lodge. Surviving are his widow and a son.

Lloyd D. Trowbridge, M. D., Piqua; University of Wooster, Medical Department, Cleveland, 1900; aged 73; died June 3; former member of the Ohio State Medical Association and the American Medical Association through 1946. Since completing his medical education, Dr. Trowbridge made Piqua the center of his practice. He was a member of the Presbyterian Church and of several Masonic orders. Surviving are his widow and four daughters.

COMING MEETINGS

American Congress of Physical Medicine, Washington, D. C., Sept. 7-11.

American Public Health Association, Boston, Mass., Nov. 8-12.

Sixth Councilor District Post-Graduate Day, Mayflower Hotel, Akron, Oct. 13.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 8.

Maternity Death Rate Down

The risk of dying during childbirth decreased during 1946, according to figures of the National Office of Vital Statistics. In that year, 5,153 women died in the United States from causes related to pregnancy and childbirth, representing a maternal mortality rate of 1.6 deaths per 1,000 live births, as compared with 5,668 deaths and a rate of 2.1 in 1945.

The national maternal mortality rate has been declining steadily, beginning with 1930. The rate in that year was 6.7, or over 4 times as large as the rate in 1946.

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THE OHIO STATE MEDICAL JOURNAL

Veterans Administration . . .

As of April, 1948, the Veterans Administration of enlistment, the date of discharge, rank, and organization be included. reported there were 18,744,000 living veterans of all wars in the nation. Of this number, 14,887,000 are of World War II. There were 252,386 veterans in training for vocational rehabilitation under Public Law 16, and 2,450,925 receiving educational training under Public Law 346.

* * *

Dr. William Reid Morrison, Boston, Mass., has accepted the post of chief consultant for surgery of the Veterans Administration.

* * *

Appointment of Dr. Lewis L. Reese, Massillon, as assistant chief of medicine for the Veterans Administration in Ohio, Michigan, and Kentucky, has been announced by Ralph H. Stone, Deputy Administrator of the V. A. branch office in Columbus. Dr. Reese received his M. D. Degree from Boston University School of Medicine in 1934 and was associated with Boston City Hospital as executive assistant until 1939, when he became medical director of University Hospital in Oklahoma City. He was a major in the Medical Corps in World War II.

* * *

Veterans Administration on June 2 awarded contracts totaling nearly \$4,750,000 for the construction of a 200-bed general medical and surgical hospital in Marlin, Texas, J. J. Rockefeller, director of V. A.'s construction service, announced.

* * *

The Veterans Administration has in its custody the majority of syphilis records of those Army personnel who were treated for this disease while in active service. It is thought that many physicians treating veterans for syphilis as private patients would find a resumé of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

According to a communication from Dr. Paul B. Magnuson, chief medical director, resumé of these records are available to physicians who are treating such veterans provided authorization for the release of the data is given by the veteran. Requests for the resúmes accompanied by an authorization for the release of the data, dated and signed by the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munitions Building, Washington 25, D. C. It is most important that the veteran's Service Serial Number and other identifying information, such as the date

Ordinarily, the resúmes can be furnished in approximately two weeks from the date of the receipt of the request and signed authorization, Dr. Magnuson announced.

* * *

"Encouraging" progress, especially in the development of new methods of diagnosis, is revealed in first reports from doctors working with the Veteran Administration's radio-isotope research program.

Dr. George M. Lyon, Chief of V.A.'s Radio-isotope Section, also revealed that leukemia patients are now being treated with radio-phosphorus in most of the seven V. A. hospitals having radio-isotope units and that another atomic pile byproduct, radio-iodine, is being employed to treat some thyroid diseases.

Reports received to date on the use of radio-phosphorus in treating leukemia indicate that unpleasant reactions frequently produced in these patients by X-ray treatment do not occur, that symptoms resulting from the disease are more readily controlled, and that the patient usually has a much shorter stay in the hospital.

Although V.A. doctors, and those assisting the agency in its research program, have been using radio-iodine for several months to aid in the diagnosis of thyroid diseases, Dr. Lyon said there is not yet sufficient information available to determine how successful it will prove for treatment.

V.A. radio-isotope units are also making studies on metabolic diseases, on circulation of the blood, and on the patency of blood vessels of the peripheral circulation.

It is expected that isotopes will continue to prove most valuable in the study of various internal diseases and that their use for treatment will be limited. Several of the nation's leading medical schools and research groups are conducting similar radio-isotope projects.

In this new research technique a radioactive substance is administered. Distribution of the radio elements in the body is then checked either by means of sensitive photographic films or with electrical impulse equipment, including the Geiger counter, the device used by engineers in atomic energy plants.

Three widely known radio-isotope scientists serve on V.A.'s Central Advisory Committee. They include Dr. Hymer L. Friedel, Professor of Radiology at Western Reserve University, Cleveland.

Radio-isotope units are located in eight V.A. hospitals including one at Cleveland. Five addi-

tional V.A. hospitals are scheduled to receive units within the next two years.

* * *

One in every 25 World War II veterans training under the G. I. Bill is preparing for a career in medicine or in a related field, a Veterans Administration survey revealed.

On December 1, 1947—date of the survey—101,447 ex-servicemen and women were enrolled in educational institutions and were training on-the-job for medical positions and professions ranging from laboratory technicians to surgeons.

More than 40 per cent, or 43,558 were studying medicine. Of these 18,265 were in pre-medical training and 25,293 were enrolled in medical schools.

A total of 17,486 were in dentistry. Of these, 7,244 were taking pre-dental training; 7,314 were in dental schools; 2,600 were studying dental mechanics; and 328 were training to be dental hygienists.

Veterans training to become pharmacists numbered 13,245. All but 890 were in schools of pharmacy. The 890 were training on-the-job in pharmacies.

A total of 5,194 were training to become laboratory technicians and assistants. About two-thirds, or 3,628, were training on-the-job, and the remaining 1,566 were enrolled in school courses.

Of the remaining veteran-trainees 6,835 were studying optometry; 4,459, nursing; 3,463, chiropractic; 1,789, veterinary medicine; 1,166, pre-veterinary medicine; 1,145, chiropody; 712, osteopathy; 357, physical therapy; 591, public health medicine; and 1,066, other types of medical services.

The V.A. survey lists occupational fields of some 2,000,000 veterans studying in schools and colleges, and 546,000 training on-the-job.

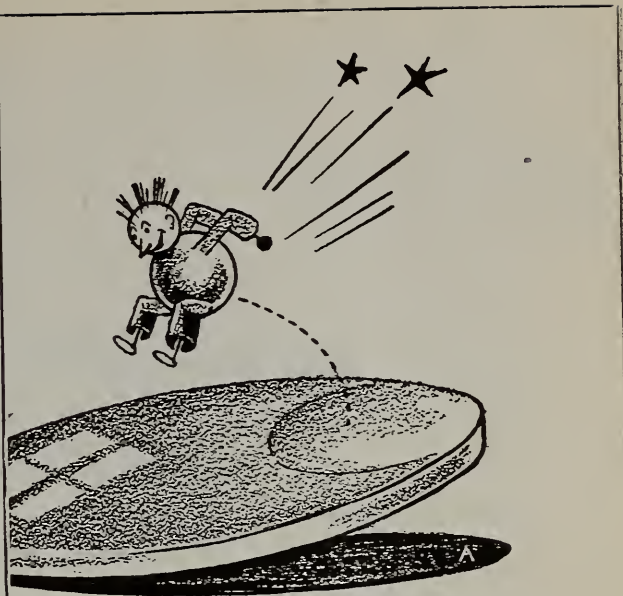
* * *

Dr. Leverett S. Woodworth, formerly assistant clinical director at Nichols V. A. Hospital in Louisville, Kentucky, has assumed his new duties as Director of Professional Services for the Veterans Administration Ohio-Michigan-Kentucky Branch Office in Columbus.

As Director of Professional Services for Branch 6, he supervises the following services: General medical, pharmacy, tuberculosis, social service, general surgery, dental, dietetic, neuropsychiatric, psychology, medical rehabilitation, and nursing.

* * *

Dr. Roy A. Wolford, of Washington, D. C., has been appointed assistant medical director for Professional Service in the Veterans Administration Department of Medicine and Surgery. A member of the V. A. medical staff since 1924, Dr. Wolford succeeds Dr. Paul B. Magnuson as chief of Professional Service.



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**Reprints of published papers on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Medical Golfers' Association To Play on July 19

Physicians interested in golf are invited to send in their reservations for the 1948 Ohio State Medical Golfers' Association Annual Tournament which will be held on the course at Granville Inn on Monday, July 19.

A handy reservation form is provided below. Mr. R. W. Elwell, secretary of the organization, would like an accurate count on the number of those expecting to take part so that all conveniences may be arranged.

Granville Inn is located at Granville in Licking County, 35 miles east of Columbus. Ice and mix are provided at the Inn, but no liquid refreshments.

Luncheon will be served at noon and a banquet will be held in the evening. For those doctors who wish to play some warm-up golf on Sunday, the course will be available. The committee has reserved all rooms in the Inn for Sunday night. However, this is a small number and requests will be honored as they are received by the secretary. The Worden Hotel in Newark will be able to accommodate some guests. Possibly others will remain in Columbus.

Participants are invited to bring ideas as to how the annual event might be improved and to suggest locations for next year's tournament.

In choosing the location for the tournament, officials explained that Granville was high on favored list as indicated by members, running even with Columbus. It was not possible to make reservations for any of the Columbus courses, they reported.

Officers of the golf association met during the Ohio State Medical Association Annual Meeting in Cincinnati and decided that the organization could now stand on its own feet.

The form below should be filled out by those interested and mailed to Mr. Elwell, secretary of the organization.

Ten Hospital Projects Approved Under Federal Program

With the last details of the Richland County Tuberculosis Sanatorium, Mansfield, submitted to the Surgeon General of the U. S. Public Health Service for approval, the first year's program of hospital projects under the Federal Hill-Burton Law has been completed.

Ten projects have been approved at an estimated total cost of \$8,407,787, of which the Federal Government will bear approximately one-third, or an estimated \$2,591,019.66. This leaves approximately \$100,000 of Federal funds to take care of possible discrepancies in cost estimations.

The hospital projects approved under the Ohio Department of Health's Hospital Facilities Office, with estimated total construction costs, are as follows: Fayette County Memorial Hospital, Washington C. H., \$529,000; Greene Memorial Hospital, Xenia, \$1,214,000; Ashtabula General Hospital, Ashtabula, \$1,274,000; Mount St. Marys Hospital, Nelsonville (Athens County), \$1,176,000; The Defiance Hospital, Defiance, \$825,000; Clinton Memorial Hospital, Wilmington, \$879,200; Mercy Memorial Hospital, Urbana, \$822,000; Richland County Tuberculosis Sanatorium, Mansfield, \$801,699; Mary Rutan Hospital, Bellefontaine, \$424,888; and Brown Memorial Hospital, Conneaut (Ashtabula County), \$462,000.

None of the areas with a high priority has suffered as a result of the first year's programming, Anthony J. Borowski, Dr. P. H., administrator of the Ohio program, reported. The state agency will proceed to develop tentatively the second year's construction program shortly after July 1, he said. Programs which potentially qualify to take part in the program and are receiving attention include the following: St. Mary's project of Auglaize County, Bowling Green, Upper Sandusky, Marion, Dover, New Philadelphia, Lorain and Elyria.

RESERVATION BLANK for 1948 Annual Meeting

OHIO STATE MEDICAL GOLFERS' ASSOCIATION

To the Secretary:

I am going to attend the Golf Tournament on July 19 at Granville, Ohio. I have enclosed a check to cover green fees, luncheon, banquet, and prizes (\$10.00).

I would also like room reservations for Sunday night, July 18. Number of Persons.....

Twin Double

Please check: New Member Old Timer

Mail To: R. W. Elwell, Secretary
Academy of Medicine
1420 Monroe Street
Toledo 2, Ohio

MAKE CHECKS PAYABLE TO OHIO STATE MEDICAL GOLFERS' ASSOCIATION

Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

A symposium was held at the June 16 meeting of the Adams County Medical Society with the following Cincinnati physicians taking part: Dr. J. H. Dornheggan, "Psychosomatic Approach to Gastro-Intestinal Disease"; Dr. E. A. Schlueter, "Hemorrhage from the Gastro-Intestinal Tract"; and Dr. J. E. Pirrung, "Surgical Considerations of Gastro-Intestinal Disease."

CLINTON

Guest speaker at the May 4 meeting of the Clinton County Medical Society in Wilmington was Dr. Bernard A. Schwartz of Cincinnati who spoke on "Congenital Heart Disease."

On June 1, Dr. Nicholas J. Giannestras of Cincinnati addressed the society on the subject, "Low Back Pain."

HAMILTON

Dr. Henry Claris Sweany, Northwestern University Medical School, was guest speaker at the May 18 meeting of the Academy of Medicine of Cincinnati. His subject was "Pathogenesis of Pulmonary Tuberculosis."

HIGHLAND

Dr. Clyde S. Roof of Cincinnati was guest speaker at the May 12 meeting of the Highland County Medical Society in Hillsboro. He discussed surgical emergencies in general practice.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

The final business meeting of the Clark County Medical Society was held on June 3 in Springfield. A summer party was held on June 23 at the Van Dyke Club.

DARKE

Dr. Bruce Martin of Columbus was guest speaker at the May 18 meeting of the Darke County Medical Society in Greenville. His subject was "Modern Treatment of Burns."

MONTGOMERY

The Annual Meeting of the Montgomery County Medical Society was held on June 2 at the Dayton Country Club. Dr. Martin Fischer, Cincinnati, spoke on "What America Owes Her Doctor."

PREBLE

The Preble County Medical Society entertained the Woman's Auxiliary at a special meeting on May 13 at which Dr. John Groff of Dayton showed pictures taken in Mexico.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

CRAWFORD

A number of members from other societies were guests of the Crawford County Medical Society for an afternoon of golf and buffet supper at the Bucyrus Country Club on May 19.

MARION

Dr. John E. Hannibal, Cleveland, was guest speaker at the May 11 meeting of the Marion County Academy of Medicine. He discussed surgical cases dealing with gallbladder disorders.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

DEFIANCE

The June 11 meeting of the Defiance County Medical Society was held at the Defiance Hospital, at which time Dr. James E. Miller of Toledo spoke on "Pelvic Inflammation Diseases." Dr. Cleon Couch of Canton, formerly of Defiance, was a visitor. The next meeting will be held on Sept. 10.

LUCAS

The site for the new academy building was discussed at the June 4 meeting of the Academy of Medicine of Toledo and Lucas County.

OTTAWA

Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association, and Dr. Carll S. Mundy, Councilor of the Fourth District, were guest speakers at the May 14 meeting of the Ottawa County Medical Society in Port Clinton.

SANDUSKY

Following separate business meetings, a joint social gathering was held on May 19 at the home of Dr. and Mrs. M. M. Riddell for members of the Sandusky County Medical Society and the Woman's Auxiliary.

WOOD

The Wood County Medical Society held a dinner meeting at Don's Point Restaurant on May 20 with Dr. Paul F. Orr, president, in charge. Dr. George H. Lemon, president of the Toledo Chapter of the Ohio Academy of General Practice, presented a paper on "The History and Factors Leading to the Organization of the Academy of General Practice and the Progress Made in the Ohio and Lucas County Organizations." Wood County now has several members of the Academy, and others signified their intention of joining. Dr. Orr reported that Dr. Lemon's talk was enthusiastically received and

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that a chapter would be formed in Wood County in the near future.

The June meeting closed the season and a dinnerdance was held at the Carronor Hunt Club on June 5 for members and their wives.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

New officers of the Academy of Medicine of Cleveland elected at a meeting of the Board on May 28 are as follows: Dr. David A. Chambers, president, succeeding Dr. C. W. Wyckoff; Dr. Fay A. LeFevre, vice-president, succeeding Dr. C. G. LaRocco; and Dr. John D. Osmond, Jr., secretary and treasurer, succeeding Dr. R. F. Parker. New directors elected at the Annual Meeting May 21 are: Drs. Clarence W. Engler, James E. Hallisy, Benjamin S. Kline, Fay A. LeFevre, Russell S. McGinnis, Robert F. Parker, Orange B. Pomeroy, and Norman W. Thiessen.

LAKE

At the April 23 clinical session of the Lake County Medical Society, Dr. H. Z. Lund and Dr. William C. McCally, Western Reserve University School of Medicine, discussed the subject, "Carcinoma of the Colon." On May 28, Dr. Gerald Schwartz, Cincinnati, spoke on "Diagnosis of Constitutional Disease With the Ophthalmoscope."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

A paper on "Recent Advances in Endocrinology" was presented by Dr. Edmund E. Beard of Cleveland at the May 18 meeting of the Columbiana County Medical Society in Lisbon.

MAHONING

Dr. Howard W. Haggard of Yale University, president of the National Committee for Education on Alcoholism, was guest speaker at the June 15 meeting of the Mahoning County Medical Society and the Woman's Auxiliary. His subject was "Alcoholism as a Medical Problem."

PORTAGE

Guest speaker at the June 3 meeting of the Portage County Medical Society was Dr. William Forsythe of Cleveland whose subject was "Diagnosis, Treatment and Prognosis of Carcinoma of the Prostate."

SUMMIT

The scientific session of the Summit County Medical Society was held on June 1 in Akron with Dr. Albert B. Sabin, University of Cincinnati College of Medicine, speaking on the subject, "Poliomyelitis."

TRUMBULL

The Trumbull County Medical Society met on April 15 with Dr. A. E. Rakoff, Jefferson



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Medical College, Philadelphia, as guest speaker. His subject was "Signs, Symptoms and Treatment of Menopausal Disturbances." On May 20, Dr. Herman Zazeela, New York City, spoke on "Signs, Symptoms, and Differential Diagnosis of Peripheral Arterial Diseases."

Seventh District

(COUNCILOR: R. J. FOSTER; M. D., NEW PHILADELPHIA)

BELMONT

Dr. R. J. Foster, New Philadelphia, Seventh District Councilor, was guest speaker at the May 11 meeting of the Belmont County Medical Society. His subject was "The Operation of a Center for the Detection of Cancer." Dr. Albert E. Winston also spoke on sidelights of the cancer problem.

Three physicians were on the program of June 10. They were Dr. A. C. Ernstene, Cleveland, who spoke on "Diagnosis and Treatment of Coronary Heart Diseases"; Dr. D. M. McGregor, Wheeling, who discussed Dr. Ernstene's paper; and Dr. Walter B. Lacock, chief of the Cancer Division, Ohio Department of Health, who reviewed the State's cancer program. Members and guests held a picnic after the afternoon program.

CARROLL

Annual dinner meeting of the Carroll County Medical Society was held in Carrollton on April 21 honoring Dr. Carl A. Lincke, president of the Society and President-Elect of the Ohio State Medical Association. Guest speaker was Dr. R. L. Rutledge, Alliance, immediate Past-President of O.S.M.A. Other guests included Dr. W. M. Skipp, Youngstown, Past-President of O.S.M.A., and Dr. R. J. Foster, Fourth District Councilor.

JEFFERSON

Regular meeting of the Jefferson County Medical Society was held on May 18 at Steubenville. The program consisted of: "Behavior Problems in Children," by Dr. Jacob R. Cohen; and "Psychiatric Problems" by Dr. S. A. Harris.

TUSCARAWAS

At the May 13 meeting of the Tuscarawas County Medical Society, Dr. Frank J. Lacksen, Columbus, spoke on "Common Skin Diseases and Their Management." Among visiting physicians was Dr. Carl A. Lincke, Carrollton, President-Elect of the Ohio State Medical Association. The special meeting was sponsored by The Wendt-Bristol Company of Columbus.

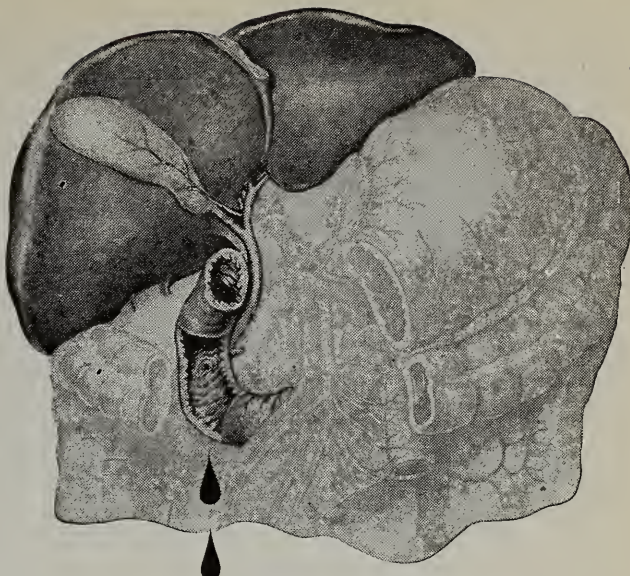
Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

MUSKINGUM

The June 2 meeting of Muskingum Academy of Medicine was held in the University Club

for July, 1948.



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.



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rooms. The speaker was Dr. Bruce C. Martin of Columbus who discussed "General Aspects of Plastic Surgery."

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D.,
PORTSMOUTH)

SCIOTO

Dr. George M. Curtis, chairman of the department of research surgery, Ohio State University College of Medicine, was guest speaker at the June 14 meeting of the Hempstead Academy of Medicine in Portsmouth. His subject was "Recognition and Management of Thyroid Disease."

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

A symposium which included on the program four University of Michigan faculty members and a speaker from Western Reserve University School of Medicine was held on May 26 by the Lorain County Medical Society. Subjects discussed by the Michigan physicians were as follows: "Treatment of Diabetic Coma," Dr. Jere M. Bauer; "Diagnosis and Management of Common Dermatological Conditions," Dr. Edward P. Cawley; "The Early Diagnosis and Treatment of Carcinoma of the Stomach," Dr. William J. Fuller, and "Emotional Factors in Disease," by Dr. Raymond W. Waggoner. At an evening session, Dr. H. L. Friedell, W. R. U., spoke on "Medical Aspects of Atomic Energy."

"Management of Virus Pneumonia" was the subject discussed by Dr. John H. Dingle, Western Reserve University School of Medicine, at the June 11 meeting.

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

The first executive Board Meeting of the Woman's Auxiliary to the Ohio State Medical Association was held on June 3 at the Athletic Club, Columbus. Mrs. E. Benjamin Gillette, Toledo, the new state president, presided. Immediately following the luncheon, Dr. H. M. Clodfelter, Columbus, spoke to the group briefly on the work of the Auxiliary.

PICKAWAY

Members of the Woman's Auxiliary to the Pickaway County Medical Society held a luncheon meeting on May 25 in Pickaway Arms. Mrs. Lloyd Jonnes presided at the business session where big plans were made for the coming year.

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Miss Letitia Gamble was received as a new member.

LUCAS

The annual election of officers of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County was held at the final meeting of the year, May 18, at the Toledo Museum of Art.

Mrs. Robert Curl, retiring president, conducted the business meeting and gave a report of the past year's activities. She then handed over the gavel to Mrs. Wendell Green, the president for the coming year. Mrs. Green gave highlights of some of the things to come. A talk was given by Miss Finvola Drury, staff member of the museum, on "Medicine and Art." Following the meeting tea was served with Mrs. J. B. Hirsch, chairman of hostesses.

The state president, Mrs. E. B. Gillette, and corresponding secretary, Mrs. Wilbur Taylor, were honored guests; as were Mrs. Harold Mouser of Marion and Mrs. J. L. Stevens of Mansfield, both past state presidents. Auxiliary presidents from Sandusky, Kenton, Fremont, and Port Clinton were also honored guests.

RICHLAND

The Woman's Auxiliary to the Richland County Medical Society held the final meeting of the season at the Women's Club, beginning with luncheon. During the annual meeting Mrs. C. R. Damron was elected president of the group and will be assisted next fall by Mrs. F. J. Heringhaus, president-elect; Mrs. H. G. Knierim, recording secretary; Mrs. G. L. Evans, corresponding secretary, and Mrs. E. H. Smedal, treasurer.

TUSCARAWAS

The May meeting of the Woman's Auxiliary to the Tuscarawas County Medical Society was held at the home of Mrs. John Lake. Thirteen members were present. Plans were made for individual members to have small card parties in their homes, proceeds to be used for the hospital fund. Suggestions for a dinner-dance and a swimming party were considered.

Clarify A. S. T. P. Service

Graduates of the Army Specialized Training Program will be released under previously effective criteria, that is, at the end of 24 months, according to a report from the Surgeon General to the American Medical Association. An officer may be released prior to 24 months by the number of days he has accrued leave or he may stay the full 24 months and draw two months' leave pay in a lump sum payment if he has not used any of his authorized leave.

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Medical Board Reviews Year's Work

At a meeting of the Ohio State Medical Board on April 6, the certificate of Harry L. Bard, M. D., Cleveland, was revoked. Dr. Bard previously was convicted of criminal abortion and sentenced to the Ohio Penitentiary.

Dr. H. M. Platter, secretary, reported the following summary of Board activities for the year 1947: Total number of cases investigated 214; investigation calls 1,613; number of cases filed 45; number dismissed 13; cases pending in court 12; cases pending from former year disposed of 47; convictions 31; total fines assessed \$6,510; total fines suspended \$2,800; total amount of money received \$1,601.

During 1947, the Board held four regular meetings and four called meetings. Two examinations were held in Columbus, in June and in December. Certificates to practice were issued to 300 graduates in medicine; 35 osteopathic applicants were successful in examinations and were issued certificates in osteopathic surgery; 119 limited practitioners were successful; 219 medical applicants were qualified and received certificates through endorsement from other states. Through entrance examinations, 676 certificates of preliminary education were issued to medical and osteopathic applicants; while 233 were issued to limited practitioners.

American Bar Criticizes Security Mirage

A recent resolution of the House of Delegates of the American Bar Association highlights little known facts about the operation of the fund accumulated under the Social Security Act which is administered by the pro-compulsory health insurance Federal Security Agency.

The resolution reveals: (1) That 99.5 per cent of the funds thus far accumulated under the Act have been spent on public projects, and that special non-negotiable Government obligations have been substituted "for 86.26 per cent thereof." (2) That "such part of such sum as may be necessary to meet extraordinary demands which may arise in the future will of necessity have to be raised by the sale of negotiable bonds or by the imposition of taxes to redeem the non-negotiable obligations."

This means that the money paid into the fund by employers and employees, comprising about 60 per cent of the taxpayers in the United States, has been spent, and that when the fund must be replaced, these same people will pay their share again to reactivate the fund. "Thus," the resolution states, "the working classes of the country which have been and are now employed are taxed doubly."

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Committee on Education in Action



Committee reports, which grow out of such discussions as the one shown above, are important factors in the formulation of Ohio State Medical Association policy established by The Council. The above scene was snapped in the Columbus headquarters of the Association as members of the Committee on Education thrashed over matters delegated to it. Members of a dozen standing committees as well as special committees travel many miles, often several times a year, to attend such meetings.

Left to right are: Dr. Edwin P. Jordan, Cleveland; Dr. Thomas E. Rardin, Columbus; Dr. J. Edwin Purdy, Canton; Mr. George H. Saville, director of public relations for the Association; Dr. Carl A. Wilzbach, Cincinnati, chairman of the committee; Dr. A. A. Brindley, Toledo, President of the Association, and Mr. Charles S. Nelson, Executive Secretary. Dr. J. L. Webb, also a member of the committee, was not present at the meeting.



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Buckeye News Notes . . .

Bellevue—Dr. H. R. Dewey recently celebrated his 50th anniversary in the medical profession.

Bowling Green—Dr. Willis S. Peck, Toledo, was a recent guest speaker at a meeting sponsored by the Women Students and campus health classes of Bowling Green State University.

Cambridge—Dr. and Mrs. W. G. Lane recently observed their 60th wedding anniversary.

Cincinnati—Dr. F. A. S. Kautz has practiced medicine for the past 50 years in Cincinnati.

Cincinnati—Dr. Marion A. Blankenhorn, University of Cincinnati College of Medicine, recently was assigned to a speaking tour in the Far East with the Army Medical Corps.

Circleville—Dr. Judson D. Wilson and Dr. Richard I. Brashear of Columbus recently addressed members of the Presbyterian Brotherhood.

Cleveland—Dr. Irvine H. Page recently addressed the City Club on the subject of hypertension. He is chairman of the medical advisory board of the American Association for High Blood Pressure.

Columbus—Dr. Herbert H. Fisher recently completed 50 years of practice.

Columbus—Dr. Horace B. Davidson, Ohio State University College of Medicine, was principal speaker at a recent meeting of the Central Ohio Society of Medical Technologists.

Dover—Dr. Daniel W. Shumaker completed 50 years of medical practice.

East Liverpool—Dr. J. Keith Rugh described wartime experiences in the Caribbean area to members of the Lions Club at a May meeting.

Hebron—Dr. George N. Brown recently celebrated the completion of 50 years of practice.

Ironton—At a recent special meeting of the Ironton Board of Education, Dr. Anne Marting Alstott was sworn in as a new member. Dr. C. A. Casey was named vice-president.

Mansfield—Dr. L. D. Bonar attended the International College of Surgeons convention in Rome, Italy, May 18-23.

Mansfield—Dr. W. E. DeVol of Marengo, medical missionary to China, recently addressed a meeting of the Mansfield Youth for Christ movement.

Marion—Dr. Warren C. Sawyer discussed the subject, "Rehabilitation and Treatment of Disease and Disorders of Later Life," at a recent Seventh District meeting of the Ohio State Nurses' Association.

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Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting Aug. 2, Sept. 13.

Surgical Anatomy & Clinical Surgery, two weeks, starting Aug. 16, Sept. 27.

Surgery of Colon & Rectum, one week, starting Sept. 20, Oct. 18. Surgical Pathology every two weeks.

FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting Oct. 25.

GYNECOLOGY—Intensive Course, two weeks, starting Sept. 13, Oct. 11. Vaginal Approach to Pelvic Surgery, one week, starting Sept. 27.

OBSTETRICS—Intensive Course, two weeks, starting Sept. 27, Oct. 25.

UROLOGY—Intensive Course, two weeks, starting Sept. 27.

MEDICINE—Intensive Course, two weeks, starting Oct. 11. Personal Course in Gastroscopy, two weeks, starting July 12, Sept. 27. Electrocardiography & Heart Disease, two weeks, starting Aug. 2, Electrocardiography & Heart Disease, four weeks, starting Sept. 13.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 4. Clinical Course every two weeks.

OPHTHALMOLOGY—Intensive Course, two weeks, starting Sept. 20. Refraction Methods, four weeks, starting Oct. 11. Ocular Fundus Diseases, one week, starting Nov. 15.

OTOLARYNGOLOGY—Intensive Course, two weeks, starting Oct. 18.

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Martins Ferry—Dr. Bertha M. Joseph was principal speaker at a meeting of the Pioneer group of the 65 Club.

Massillon—Dr. Henry P. Hart was a recent speaker at the Massillon Rotary Club. He described experiences on a recent trip to the Canadian Rockies.

Middleport—Dr. George G. Hunter, president-elect of the Ironton Rotary Club, was guest speaker at a meeting of the Middleport Rotary Club.

New Concord—Dr. Isaac W. Curtis was appointed a member of the board of directors of the First National Bank of New Concord.

Newark—Dr. James H. Pollock has been named Licking County coroner to fill the unexpired term of the late Dr. G. W. Sapp.

Norwalk—Dr. Charles H. Edel recently accepted the appointment as deputy coroner of Huron County. He replaces Dr. W. W. Corwin of Willard who resigned.

Painesville—The principal speaker at the annual dinner meeting of the Lake County Registered Nurses' Association on May 25 was Dr. Charles C. Higgins of Cleveland.

Painesville—Dr. Richard E. Stout, addressed a recent meeting of the League of Women Voters on the subject, "Mental Health and What Are Ohio's Needs?"

Port Clinton—Dr. A. D. Miessner addressed a recent meeting of the Rotary Club on the subject, "Heart Ailments and Their Causes." Dr. Gordon R. Ley took part in a round-table discussion.

Shelby—Dr. Harry A. Duncan, Millersburg, was principal speaker at the annual meeting of the Hospital Guild.

Toledo—Dr. Carll S. Mundy, Toledo, Fourth District Councilor, addressed a recent joint meeting of the Lucas County Pharmaceutical Association and the Northwestern Ohio Branch of the American Pharmaceutical Association.

Urbana—Dr. George M. Curtis, Ohio State University College of Medicine, recently gave a public address on the subject of cancer.

Warren—Dr. Aubrey L. Sparks recently addressed the Y. M. C. A. Pre-Marriage and Home Forum.

Mortality of Physicians

"Longevity and Mortality of Physicians" is one of a number of studies in pamphlet or exhibit form available from the Metropolitan Life Insurance Co., 1 Madison Ave., New York 10. The study shows that while the life expectancy of physicians is slightly greater than for the general population at age 25, by the age of 45 the reverse is true.

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Opinions of Attorney General

Following are abstracts of recent opinions rendered by Attorney General Hugh S. Jenkins:

Syllabus of Opinion No. 3147: Under the terms of the Hospital Reimbursement Law (Sections 6308-7 to 6308-15, inclusive, of the General Code), the registrar of motor vehicles shall determine the amount of any claim in accordance with the per diem cost of such hospital as certified to him by the director of health, less any amount collected by the hospital from the patient. Such certified rate shall be applied for the full period of time a patient is hospitalized in making a determination as to whether reimbursement is authorized. If the amount actually collected by a hospital equals or exceeds the total amount for which reimbursement would otherwise be authorized, then in such event said registrar is without legal authority to make any payment on a purported claim for reimbursement.

Syllabus of Opinion No. 3131: 1. An indigent person who is injured while being apprehended by peace officers in the perpetration of a felony, is not entitled to receive hospital care while in custody under the provisions of Section 3484-2, General Code, or any other poor relief provisions of the General Code. (1945 Opinions of Attorney General, Opinion No. 361, page 420, overruled.) 2. The political subdivision of the state, either city or county, which has custody and control of an indigent person, injured while being apprehended by peace officers in the perpetration of a felony, is responsible for necessary hospital care.

The syllabus of Opinion No. 2921 reads: "A rest home, convalescent home, or boarding home for the aged or mentally or physically infirm, which is conducted and maintained by a person, firm, partnership, association, or corporation, whether the latter be organized for profit or not for profit, must, if consideration is demanded and accepted from or on behalf of any or all of

the inmates of such home, be licensed in accordance with the provisions of Section 6289-2, et seq. General Code."

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The Physician's Bookshelf

By Jonathan Forman, M.D.

Life Is for Living, by D. Ewen Cameron, M.D., (\$2.75. *Macmillan Company, New York City*) has been written for those who are trying to grope their way through the confusion and contradictory absurdities, the mortal dangers, and the psychological pestilences of mid-century living. It is by the distinguished professor of psychiatry at McGill University. You will find many chances to loan this book to your patients if you put it on your shelf.

The American Hospital, by E. H. L. Corwin, Ph.D., (\$1.50. *The Commonwealth Fund, New York City*) is an authentic and comprehensive treatise on hospitals assembling a wealth of information in a relatively small volume. All who are in any way interested in hospitals will want to own and study a copy as will all students of Medical History.

So Youth May Know. Sex Education for Youth, by Roy E. Dickerson, (\$2.50. A Revised Edition. *Association Press, New York City*) has been revised with the idea that boys of fourteen should read it instead of older boys. In its former edition it enjoyed wide circulation and will no doubt do so again.

The Acute Bacterial Diseases; Their Diagnosis and Treatment, by Harry F. Dowling, M.D., (\$6.50. *W. B. Saunders Company, Philadelphia*) is thoroughly modern in its approach. While it emphasizes our newer methods of treatment, it also gives ample space to the great improvements in laboratory diagnosis and to the attitude of the physician. It treats of diseases caused by cocci; diseases caused by bacilli; and diseases caused by exotoxins of bacteria.

Biology of Disease, by Eli Moschowitz, M.D., (\$4.50. *Grune and Stratton, New York City*) insists that chronic diseases, like biologic species, present an evolution from the primitive to the full-fledged form. What we forget all too frequently is that our medical writers whose lives center in hospitals, see only a very small cross section of disease—the terminal one. Current statistics in nosology lose all, or nearly all, of their value because the recording clinician does not note in what phase of the disease process the symptoms occurred. Here we are given a methodology and a most stimulating point of view.

Textbok of Gynecology, by Emil Novak, M.D., (\$8.00. Third Edition. *Williams and Wilkins Company, Baltimore*) presents no radical changes over the popular second edition. Many excellent and new illustrations have been included.

Encyclopedia of Medical Sources, by Emerson Crosby Kelly, M.D., (\$7.50. *Williams and Wilkins Company, Baltimore*) is a most helpful collection of medical eponyms and original works. If, for instance, you wished to know where McBurney's point is, you turn to page 265 and find that more than a half of our teachers of surgery are wrong. A must for all who write in the field of medicine and for the editors who check them.

Clinical Diagnosis by Laboratory Methods, by James C. Todd, M.D., and Arthur H. Sanford, M.D., (\$7.50. Eleventh Edition. *W. B. Saunders Company, Philadelphia*) has been a standard text ever since I began the study of the subject nearly forty years ago. Again the text has undergone extensive revision to keep it among the best in its field.

The Chemistry of the Blood, by M. R. DeHaan, M.D., (\$2.00. *Zondervan Books, Grand Rapids, Michigan*) is a series of messages on the scientific aspects of the Gospel of the Grace of God. They were first broadcasted over a coast-to-coast network of the Mutual Broadcasting System.

Diabetes and the Diabetic in the Community, by Mary E. Tangney, R.N., (\$2.75. *W. B. Saunders Company, Philadelphia, Pennsylvania*) is based on the importance of teaching the diabetic person who lives in the community rather than the nursing of the diabetic patient who is in the hospital.

Symposium on Medicolegal Problems, edited by Samuel A. Levinson, M.D., (\$5.00. *J. B. Lippincott Company, Philadelphia, Pennsylvania*) was held under the co-sponsorship of the Institute of Medicine of Chicago and the Chicago Bar Association. Fourteen distinguished authors attempt to clarify the common and mutual problems.

Neuroanatomy, by Fred A. Mettler, M.D., (\$10.00. Second Edition. *C. V. Mosby Company, St. Louis*) contains new material on the blood supply and venous drainage of the various parts of the neuraxis. It stands well prepared to its assigned task of meeting the needs of the medical student beginning neuro-anatomy. It will also stand him in good stead in his future clinical training.

The 1947 Year Book of Pathology and Clinical Pathology, edited by Howard T. Karsner, M.D., (and Herbert Z. Lund) and Arthur H. Sanford, M.D., (\$3.75. *The Year Book Publishers, Chicago*) is the first of the series to appear

since 1941. It is again a helpful book for the pathologist, the clinical laboratory worker, and the allergist.

Conversations on Success in Marriage, by Napoleon W. Lovely, (\$1.50. *Beacon Press, Boston*) presents a series of conversations with a liberal Christian army chaplain on the problems of marriage.

What Is Psychoanalysis? by Ernest Jones, M.D., (\$2.00. A New and Enlarged Edition. *International Universities Press, New York City*) is an attempt at a popular explanation of the subject, its contents, and its applications.

The Battle of the Conscience, by Edmund Bergler, M. D., (\$3.75. *Washington Institute of Medicine, Washington, D. C.*) is a psychiatric study of the inner working of the conscience. It investigates the genesis and working ramification of the normal conscience. This is a field of many contradictions in which this volume is a helpful guide, especially for those of us who believe that there is a fixed congenital attribute by which a personality has or has not the power to conform to the social customs of his time.

Upstart, A Novel, by Dorothy E. S. Hansen, \$2.75. *Sage Books, Inc., Golden, Colorado*) is dedicated to all the patients with all the hangovers.

War, Politics, and Insanity, by C. S. Bluemel, M.D., (\$2.00. *The World Press, Inc., Denver, Colorado*) is a psychiatric study of politicians, their genesis, their personality, and from what disorders of personality do they suffer.

How Man Discovered His Body, by Sarah R. Riedman, Illustrated by Frances Wells, (\$2.25. A Young World Book. *International Publishers, New York City*). A marvelous job of telling youngsters what we know about our bodies and how we found it out. The history of physiology for youngsters. It is great!

This Man and This Woman, by Frederick W. Brink, (\$1.50. *Association Press, New York City*) is a brief guide for those contemplating marriage published by an international committee of the Y. M. C. A.

Divorce Won't Help, by Edmund Bergler, M. D., (\$3.00. *Harper and Brothers, New York City*) approaches marriage problems with the idea that there is nothing wrong with marriage but that there is a lot wrong mentally with the people who enter into marriage. In fact, it is a study of the neurotic in the field of marriage.

Fundamentals of Human Reproduction, by Edith L. Potter, M. D., (\$3.50. *McGraw-Hill Book Company, New York City*) is human embryology told and illustrated in a manner that should put to shame many of our teachers in

medical school. It is factual; it is clear and easily understood by anyone with intelligent curiosity.

Source Book of Orthopaedics, by Edgar M. Bick, M. D., (\$8.00. Second Edition. *Williams and Wilkins Company, Baltimore*) is the first revision in ten years. It is a must for everyone interested in bone and joint surgery and in the history of medicine.

Chemical Architecture, edited by R. E. Burk and Oliver Grummitt, (\$4.50. *Interscience Publishers, New York City*) contains the 1947 lecture of Western Reserve University's "Frontiers in Chemistry" series. These deserve a place in the science library not only for their content but because they offer instruction in a fresh technique for keeping up with the forward movement of science.

Taking the Cure, by Robert G. Lovell, M. D., (\$2.00. *Macmillan Company, New York City*) was written for the new tuberculosis patient to give him encouragement and answer some of the questions running through his mind.

Doctor Kim, by Lucy Agnes Hancock, (\$2.00. *Macrae-Smith Company, Philadelphia*) is an entertaining novel with a physician for its leading character.

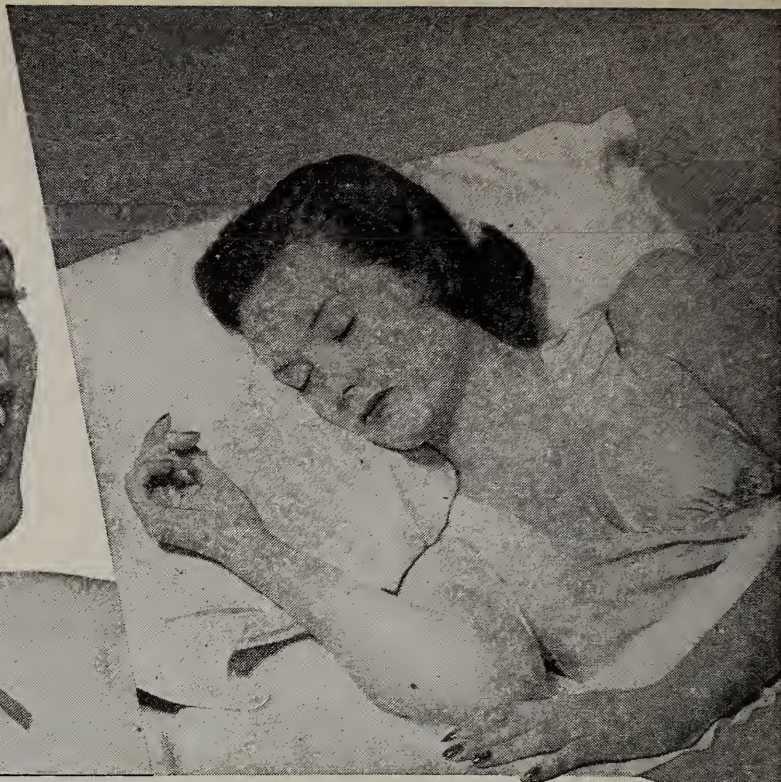
Synopsis of Pediatrics, by John Zahorsky, M.D., (\$5.50. Fifth Edition. *The C. V. Mosby Company, St. Louis*) includes the new drugs and other material to bring the manual up to date.

Food, Nutrition, and Health, by E. V. McCollum and J. Ernestine Becker, (\$2.00. Sixth Edition. *Published by the authors, Gilman Hall, Johns Hopkins University, Baltimore*) presents in the most acceptable way the facts about food and health. This little manual has been a dependable book and reference since 1925.

Old Age: Its Compensations and Rewards, by A. L. Vischer, M. D., (\$3.50. *Macmillan Company, New York City*) is filled with the ripe wisdom developed after twenty years of work with the old people of Basle.

The Biological Standardization of the Vitamins, by Katherine H. Coward, (\$5.00. Second Edition. *Williams and Wilkins, Baltimore*) is intended for those who are engaged in the determination of the vitamin potency of foods, drugs, and preparations intended for research.

History of the Medical Society of the County of Westchester (N. Y.). 1797-1947. (*The Medical Society of the County of Westchester, New York*) is a compilation of the available minutes of the Society and various contemporary sources during the years for which the minutes were lost. This should stimulate more of our county societies to preserve their story in a similar fashion.



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Cholinergic Episodes and States in the Human.

I. Deductions from the Occurrence of Systemic Cholinergic Reactions from Typhoid Vaccine*

ROBERT D. BARNARD, M. D.

IN previous reports,^{1,2} clinical evidence was adduced for the possible role of an acetyl choline-like substance in the production of a certain shock-like state; blood donor syncope. For this condition it was postulated that a cholinokinetic substance or group of substances was elaborated into the general circulation giving rise to a temporary cholinokinetic intoxication. In an individual whose constitutional predisposition lay in the fact that there were inadequate skin vascularity and musculo-venous-pressor mechanism, such intoxication, if transient, would be manifested by syncope; if protracted might result in surgical shock.² In ordinary blood donor syncope, the presumed cholinokinetic hormone overflow was considered to be transient because of the rather temporary nature of the psychogenic (cerebral subcortical) stimulus entailed by simple venipuncture.

Later³ an extension to include shock-like conditions in which a protraction of a cholinokinetic state was postulated. Protraction could take place by the continued elaboration of cholin-

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kinetic hormone by the hypothalamus or through the prolongation or augmentation of the effects of the latter by additional sources of systemically occurring cholinokinetic substances. Enumerated among the last were choline, iminazoly, and guanidyl derivatives. These substances are normally extant in the animal organism, either free or combined; their liberation in a pharmacologically active form occurring under certain circumstances.

If any of these cholinokinetics are produced in quantity, "true" or secondary shock is likely to supervene again, particularly in that type of individual whose physical and psychic habitus renders him prone to morbid manifestations from cholinokinesis.

Syncope reactions are by no means limited to blood donors; in fact, they are extremely common throughout the armed forces. Wartime conditions have brought instances related to syncope to the foreground. This statement implies more than the obvious fact that more people subject to emotional stress are under

* For the facilities afforded in carrying out the observations on cholinokinetic episodes which have extended throughout three years of military service, the author wishes to cite his indebtedness to those who have been most generous and in particular to the late Commander L. M. Rogers of the U. S. Public Health Service, Colonel Ralph Fouser of the Army of the United States, and the Ciba Pharmaceutical Products, Inc., Summit, N. J., who provided, without cost or stint, many expensive chemicals and drugs for the study of purely academic phases of the problems involved.

Submitted March 8, 1946.

medical scrutiny or even that emotional stress follows *pari passu* from wartime conditions. That global war itself was a psychosomatic manifestation of some indefinable cyclic change in the humoral organization of the average person is a hint given by the variety and dispersion of cholinokinetic episodes now being observed; at least this thesis cannot be dismissed in an impartial scientific inquiry. Waxing and waning cycles of bizarre mass psycho-motor phenomena are age-old; witness the dancing and flogging crazes of the middle ages. When a clinician attempts to say that the psychomotor phenomena seen during this upheaval are different than those observed after the last (circumscribedly) global debauch; that the tension states and "psychoneurosis" that make up fully one-third of our war casualties are quantitatively, at least, different than the "effort syndromes" and "shell shock" and "disordered action of the heart" of the last war, he exposes his thesis to the legitimate criticism that he, like the rest of his subjects and the world itself, is moving with the cycle; that like the true fixed "universal observer" defined only in negative terms by the laws of relativity, his observations can have meaning only in relative terms.⁴

Still, diseases do have cycles, that even the relatively-placed observer can note; scarlet fever is different than it was in 1925; so, most certainly, are the venereal diseases. That psychosomatic disease rates are on the upswing and that their manifestations are changing is the opinion of this observer. That there is an undercurrent of ubiquity in many of these manifestations is another opinion. On the basis of a description of these manifestations, as observed during military service, an attempt will be made to elucidate the nature of this ubiquity.

From an interest in blood donor syncope, it was natural to study subjects exhibiting syncopic episodes as a result of other incitants. In military practice the latter arise most frequently in three connections: (a) Medical and surgical "shock"; (b) disorders resulting from abnormal motion and position; and (c) during the course of immunization with typhoid vaccine.

Since all soldiers are subjected to the last incitant, while relatively few may be subjected to (a) or (b), it was found that the greatest number of instances observed were as a result of (c). A closer scrutiny of systemic reactions to typhoid vaccine revealed a remarkable basis for an approach to the study of human cholinokinetic reactions in general. Aside from the rather tenuous uniformity that all forms of reactions to typhoid vaccine usually took place about one day after the second dose, the reactions themselves were so diverse in manifestation, superficially, that were the etiologic agent not to be assumed to have been imposed

under "experimental" conditions, the suggestion of a common relationship of these manifestations could scarcely be hazarded.

By virtue, however, of this common etiologic principle, or its antecedent, the second dose of killed typhoid bacilli, analysis of each of these diverse manifestations was carried out. Each was found to have (A) a definite descriptive category into which it fit; (B) a counterpart for each member of this category in the form of a clinical entity not ordinarily considered as being related to the administration of typhoid vaccine; and (C) a leading symptom of the entity so related under (B) partaking of the nature of the manifestation listed descriptively under (A). The type of manifestation elicited by reaction to typhoid vaccine appeared to depend (D) on the physical habitus of the individual and (E) each of these manifestations could, in turn be elicited by the administration of toxic doses of some known cholinokinetic drug. (Table I.)

On the basis of the last fact, but only tentatively, we may assume that human reactions to typhoid vaccine are cholinokinetic. Other, more potent reasons for such a designation appear after an analysis of these episodes, in detail. They will be described and an attempt will be made to justify the assumption of a cholinokinetic basis, for by doing so, the same generalization is reached on an inductive basis. It is believed that the benefits of such a delineation, if only from a standpoint of formal classification, warrants the presentation of the thesis in the manner and order in which it has been evolved.

TYPHOID REACTION PHENOMENA

Systemic typhoid vaccine reactions, in the author's experience, occurred in between one and two per cent of all American troops inoculated during the present war. This seems to be a higher incidence than was noted during World War I; a situation which must be regarded as peculiar, since many of these reactions are of the "anaphylactic" type and some attempt was supposed to have been made during the present mobilization to exclude those of known allergic diathesis. The reactions usually described as "convulsive"⁵ have turned out to be only one of several distinct types encountered. The latter are descriptively listed under (A) in Table I. Almost invariably the reactions (whatever the type) follow within 24 to 48 hours after the second dose of the first series and are rather short-lived; a matter of minutes. The order of frequency of appearance of the different descriptive types follow in the sequence given by Table I; this, however, cannot be relied on as true relative incidence for the convulsive and asthmatic types, being most spectacular, are more fre-

quently called to the attention of the medical officer. The actual over-all incidence of the reactions may thus likewise be under-estimated; occurring as they do in newly inducted troops whose natural diffidence prevents them from bothering what they consider to be a busy dispensary surgeon.

The classification into (A) types of reaction is practical and based entirely on the predominant symptom shown by the reactor.

A-1, the syncopic, and A-2, the convulsive reaction, will be described together since, as pointed out in the blood donor reactor study, these are considered to be merely separate phases of a single syndrome.¹ The manifestations are identically those that have been described for blood donor syncope. In fact, after observing typhoid vaccine reactors, a return to blood donor observation has enabled verification on the latter of the little additional information obtained on this syndrome. The purely syncopic reactor may not faint at all but complain of feeling ill, show pallor, sweating and bradycardia. He is usually a brunette with the diminished skin vascularity and hypoplastic musculo-venous system previously described.² The latter also holds for the reactor showing a predominant convulsive phase, though he tends to be fair complexioned and frequently has reddish hair. Actually his skin capillarity is no greater, though he may appear less pale than the brunette because of lesser pigmentation. He does not complain of feeling ill, but goes directly into an epileptoid seizure lasting for a few seconds, after which there may or may not be a shock phase. When these individuals react by convulsions to venipuncture; they are labelled as epileptics, whether justifiably or not, cannot be stated—when the seizure occurs following typhoid vaccine, the latter is held accountable and the episode dismissed. Again no point is made either way on justification. Very occasionally, an epileptoid phase develops shortly after the inception of a shock type of syncope syndrome; this negates the previous statement by the author that a reversal of the epileptoid-shock sequence in the syncope syndrome has not been observed. It has, in this connection as well as in blood donor center practice.³ It is, however, very rare.

A-3. Visceral atopic reactions following typhoid vaccine administration, are spectacular. The individual is always obese and ruddy (the "pyknic" type). The episode is ushered in by a heightening of skin color and copious perspiration that "runs" rather than gathering in the "beads" seen on the forehead of the syncope reactor. An asthmatic attack supervenes, often so severe that the patient lies helpless; inspiratory as well as expiratory effort being ac-

companied by audible wheezing. Breathing fremitus is marked. The conjunctiva is injected; this not due to the respiratory effort because it has been observed before the latter becomes evident. Lacrimation and rhinorrhea are profuse. The attack lasts for several minutes. Symptoms identical with the above in their sequence and duration have been produced in an atopic typhoid vaccine reactor by the subcutaneous administration of .03 gm. of acetyl-beta-methyl-choline.

Cutaneous atopic reactions are infrequently observed unless one wishes to include among them, those inflammatory local indurations which itch severely. Urticarias themselves are rather uncommon, but three instances have been noted by the author in which their appearance seemed to be casually related to the administration of the vaccine.

A-4. Fibrillary Reactions. Following the administration of any dose of the vaccine but particularly the second, a slight elevation of temperature and slight malaise is the rule. This is ordinarily ascribed to "foreign protein" effect and can hardly be regarded as an untoward reaction. In some individuals, however, there is a tardy, ephemeral paroxysm of chill and fever. Such episodes are believed to bear a relationship to an afebrile type of response, that has been designated as fibrillary and usually takes place in older individuals, of a ruddy complexion, non-obese, of good muscularity and is characterized by fine tremors or frank chill. The duration is a matter of minutes. Because the fine tremor of the extremities of muscles of mastication may shade insensibly into the rigors of a pyrogenic reaction, the classification as "fibrillary" is preferred for this type of episode. At one pole of the fibrillary type there is a response remarkably like that of the psychomotor response to anger and at the other, a complete component of a malarial paroxysm. That the opposite poles of the fibrillary reaction are quantitative degrees of a single entity is a deduction which will follow from the analysis of these reactions as a whole.

A-5. Tetany has been observed in two instances. Whether the individuals concerned were spasmophilic is not known but no episodes previous to typhoid vaccination were recalled. There were coarse tremors of the arms and in one, carpopedal spasm. In the latter, the condition persisted unabated for about a half hour and vanished during the course of an intravenous injection of calcium gluconate. Tetany reactions are rather common in blood donor center and even in induction center work. In the latter instance they undoubtedly have a psychogenic inception. While this does not infer that tetany reactions after typhoid vaccine are psychogenic;

a denouement is faced when we consider that all of the protean reactions following typhoid vaccine have likewise been known to occur as psychomotor phenomena.

This brings another point of universality to the fore; we may use it either to fortify the hypothesis that typhoid vaccine reactions are cholinokinetic after accepting their psychosomatic counterparts to be so, or, in this instance, take the more difficult case; elucidate the premise that the vaccine reactions are cholinokinetic and reach the conclusion that they represent only one aspect of a group of reactions peculiar to the mammal, but reaching in the human a degree of culmination that make them one of the leading medical topics of the times; psychosomatic reactions. As we shall see, the term is unfortunate, because these manifestations in the human are conditioned only by a peculiarity of structure wherein the brain, by its massive relative size becomes, not only the master somatic ganglion of the body, but an organ of internal secretion as well. As such, it may act either as an initiating or sustaining structure for protracted cholinokinesis.

This concept is an extension of the limited hypothesis developed previously to explain the manifestations in psychogenic "shock" or syncope.³ To validate this extension, the underlying basis of atopic reactions in the mammal will be explored and the relationship of these limited manifestations to the more general case of cholinokinetic reactions in the human will be established.

THE CHOLINOKINETIC NATURE OF ATOPIC REACTIONS (ALLERGY AND ANAPHYLAXIS)

The humoral concept of the genesis of atopic reactions, in which histamine has been brought forth as the chemical agent involved, is still a very controversial matter. The case for and against histamine is well presented by Ratner.⁷ The acetylcholine hypothesis is a more recent one and it, likewise, is an open question.⁸ The issue of the exact nature of the humoral substance involved is avoided by pointing out that the effect of any parasympatheticomimetic drug depends entirely on individual reactivity to that drug; that although the effects of anaphylaxis in the guinea pig, rabbit, dog, and human are superficially different, the phenomena exhibited during anaphylactic shock in any of these animals is one of profound parasympathetic stimulation. It cannot be ignored that the antiesterase cholinergic drugs are those to which systemic atopy is most frequently manifested in the human (viz, quinine) and this fact, along with the other; that acute systemic atopy in the human may be duplicated in every feature by administration of the classic cholinokinetic, acetylcholine, and

histamine forms prime evidence for the position that atopy is a cholinokinetic manifestation.

Current pharmacologic studies in which certain chemical common property characteristics are found to reside in most cholinokinetic drugs as well as recent investigations on cholinesterase which shows it to be a group of enzymes or even a "physiologic activity" rather than an entity, may serve to counter the point that individually incriminated specific cholinokinetic substances are not always found in the circulation in acute atopic conditions, or if found on occasions, or in individual cases, are too inconstantly present to be incriminated as the pharmacodynamic agents involved. This point may be answered by the statement that various amines, peptones and certain inorganic ions, extremely difficult of detection or quantitative estimation in complex biologic situations, or too unstable to survive withdrawal from the body, may be effective cholinokinetics. The laboratory investigator who has withdrawn blood from a subject in an acute atopic state, fails to demonstrate any effect thereof on a strip of guinea pig uterus or frog rectus and draws a definite conclusion from his negative result, fails to realize that the bronchiolar musculature or capillary bed of the subject has already conducted a biologic assay on his own circulating biologic fluid to a greater degree of conclusiveness and under more ideal experimental conditions than the laboratory investigator could ever approximate.

Any feature of clinical atopy may be duplicated in its entirety as a manifestation of one of the other tabulated episodes, in at least two of which (tension states¹³ and pyrogenic episodes¹⁴) the presence of cholinokinetics has been demonstrated in the blood. On this basis a relationship is indicated between atopy and those other presumably cholinokinetic clinical manifestations which arise under circumstances in which connection atopy as an etiology factor, does not enter.

CHOLINOKINETIC BASIS OF THE PSYCHOGENIC SYNCOPE-SHOCK SYNDROME

This has been discussed in previous papers.^{1,2,3} Whereas in atopy, the liberation of the cholinokinetic may be from the shock organ, the blood (Code and Hester⁹) or the liver (Dragstedt¹⁰) the source in the case of the syncope-shock syndrome is undoubtedly the cerebral gray matter. In the instance of the human, who is predominantly a cholinergic animal (Alexander¹¹) the basal ganglia are constantly synthesizing a large amount of acetylcholine and while the elaboration is probably designed for local consumption in the activation of intrinsic synaptic functions; that there will be a systemic overflow under conditions of exaggerated thalamic or hypothalamic activity is inescapable. In fact, the systemic diversion can be considered a phy-

siologic event. Just as the chromaffin system humorally distributes its activating agent, adrenalin; the master somatic ganglion probably uses, during emergency activity, its own activating agent, humorally dispatched to reinforce the impulses which it has channeled through strictly nervous pathways to the site of its (the master ganglion's) elected action.

This concept clears the difficulty hitherto posed to the reconciliation of humoral hypotheses of both allergic and surgical shock—the question of why, for instance, histamine or acetylcholine if it should be disseminated, affects preponderantly the bronchiolar musculature of the sensitized guinea pig, but in the case of the dog, the alimentary tract is most affected. Setting aside for the moment the question of what chemical is specifically the “cholinergic” hormone; an explanation on the basis of species difference is legitimate, for we have seen that even in the human there can be at least five, apparently totally dissimilar systemic responses to the atopy induced by typhoid vaccine sensitization. With this difference within one species, what difficulties of explanation could the hormonal theory of atopic reactions of indifferent species present?

Actually the question of the circulation of a hormonal cholinokinetic was settled many years ago by the classic work of Loewi¹² on “vagus-stoffe,” for here with the stimulation of only the restricted gray matter represented by the cardiac vagal terminations, a blood stream overflow could be detected. What of the far more

the periods when cerebral and general metabolic activity are greatest. The diurnal temperature curve reflecting metabolic activity places the peak of the latter in the afternoon and evening hours, for most humans. It is during these hours that the bulk of donor syncopic reactions occur. The same was true of observed typhoid vaccine reactions, whether syncopic or otherwise. In donor syncope there was the added cholinokinetic increment of a tension state superimposed on a normal diurnal peak point of physiologic cholinokinetic hormone overflow which threw the predisposed subject into cholinokinetic shock. In the typhoid vaccine reactor, the atopy of the latter summates similarly with the normal cholinokinetic peak to throw the subject into atopic shock, whatever form the last may take.*

Predicating a normal cholinokinetic peak, we are in a position to consider the pattern of another general type of reaction:

CHOLINOKINETIC NATURE OF THE FIBRILLARY-PYROGENIC REACTION

On superficial analysis nothing would seem so far-fetched as to attempt an establishment of parallelism between that prototype of human cholinokinetic reactions, the syncope syndrome, and that which we have tentatively designated as cholinokinetic on the basis of its inclusion in the typhoid vaccine reactions; the fibrillary type. As clinical counterparts of the latter, Table I lists sepsis, hectic fevers, and hyperthy-

TABLE I
Classification of Cholinokinetic Reactions

(A) Type	(B) Clinical Counterpart	(C) Characterization of Reactor	(D) Leading Symptom	(E) Drug Inducing Condition Experimentally
1. Syncopic	Shock Phase of Syncope Syndrome	Brunette—"vagotonic"	Fainting	Acetylcholine
2. Convulsive	Epileptoid Phase of Syncope Syndrome	Fair—"vagotonic"	Grand Mal	Acetylcholine
3. Atopic-Exudative				
(a) Visceral	Bronchial Asthma	Ruddy-obese—"plethoric"	Pulmonary Edema, Diaphoresis, Lacrymation	Acetyl B methylcholine
(b) Cutaneous	Urticaria	No definable type	Hives, dermatographia	Histamine
4. Fibrillary-Pyrogenic				
(a) Tremulous	Hyperthyroidism	Ruddy-muscular	Tremor	Guanidine, carbimid
(b) Chills and fever	Malaria, sepsis	No definable type	Chills and fever	Toxins
5. Tetanic	Spasmophilia	No definable type	Tetany	Guanidine, strychnine, Tetanus toxin

massive gray matter of the basal ganglia whose synthesis of acetylcholine can be demonstrated in vitro? Considering the difficulties that at first attended the confirmation of Loewi's work, it is understandable that the systemic presence of a cholinokinetic substance could only recently be detected experimentally with consistency.¹³ And this, only in "tension states" when the activity of the basal ganglia, either autonomous or under cortical impellation is highest.

We may predicate that the physiologic output of cholinokinetic hormone will be highest during

roid crises. Even the latter component of the purported parallel seems to be a hodge-podge. Yet analysis from every angle of experimental and clinical data draws this parallel so closely as to approximate a generic identity. The first

* If, to these two sources there is added cholinokinetic hormone elaboration as the result of a tension state, the latter may appear to be the trigger mechanism for precipitating the atopic manifestation. This is the underlying basis of the "emotional allergies", most of whose manifestations either appear during the latter part of the day or, having appeared earlier, if untreated, become more severe as the day wanes. There must, however, be an underlying sensitization to whose cholinokinetic contribution, the emotional state can merely add.

of these angles is the demonstration of a cholinokinetic circulating substance (in this case; a protein) as the chemical basis of fever in inflammation by Menkin.¹⁴ Septic fevers are, therefore, in part at least, cholinokinetic phenomena.

From the physiologic angle, the periodicity of the septic temperature curve emulates and amplifies the normal diurnal temperature curve rising during the day, reaching its peak in the evening and dropping during the night to lowest level, even to subnormality, in the early morning hours. In malaria this diurnally synchronized temperature periodicity has been attributed to a maturation periodicity on the part of a complexly developing parasite (though in light of recent knowledge this idea can be entertained no longer) but there is no such cyclic periodicity on the parts of the typhoid bacillus or the pneumococcus. It is hardly likely that an inherent periodicity exists in whatever is the etiologic agent of the Pal-Ebstein type of Hodgkins. The differential between the high and low points of the diurnal temperature curve represents the intrinsic cholinokinetic contribution, some of which must undoubtedly be from hypothalamic elaboration. The patient, when mentally disturbed, shows a degree of fever above that warranted by his illness. In this respect, fever, or at least its augmentation by subcortical cholinokinetic stimulus, is just as much psychogenic as is the syncope syndrome. However, the subject, even though he be, when afebrile, the syncope reactor type, by virtue of the fever, his constitutional predisposition has been altered. The subject with fever lacks, by virtue of the latter, the peripheral vasoconstriction necessary for profound cholinokinesis to produce syncope unless medical shock supervenes. When and if this transpires it has been the result, as in the comparable case of traumatic shock, of sustained cholinokinesis, the agents in this case being those of autochthonous human and bacterial toxic cholinokinetics.³

MODULATION OF PYROGENIC REACTIONS

The classic pneumonia crisis during which the temperature and heart rate fall, a copious sweat breaks out and the patient experiences a sense of relief at the completion of the "humeral chain reflex"³ is, in essence, a physiologic duplication of the shock phase of the syncope syndrome as previously described.

The augmentation of the febrile episodes by incretory cholinokinetics is attested by the efficacy of analgesic drugs as the coal tar antipyretics, all of which are analgesic through their action on the cerebral centers. By the latter action, they vitiate the cortical influences which maintain basal ganglion activity and in this manner, likewise they may abrogate cholinokinetic activity.

Pyrogenic reactions from unsuitable intravenous infusion set-ups likewise occur chiefly in the latter part of the day. An experimental study with a known pyrogen has shown that the reactions are elicited most readily in those who have the "vagotonic" habitus of the syncope reactor.¹⁵

Hyperthyroid crises have been included among the cholinokinetic fibrillary reactions on the basis of recent experimental findings. Hyperthyroid dogs are thrown into surgical shock much more readily by intestinal manipulation than are otherwise normal dogs (Schachter and Huntington¹⁶). The notion that hyperthyroidism in the human was a sympathetomimetic syndrome has been based on pharmacologic surmise which from a standpoint of human pharmacodynamics does not withstand scrutiny. Each of the symptoms of thyrotoxicosis may be produced by the administration of "cholinergic" drugs. Patients in acute tension states in whose blood a cholinokinetic can be demonstrated and patients with fibrillary reaction from typhoid vaccine exhibit a transient picture remarkably like that of the patient with toxic goiter. The evanescence of an acute cholinokinetic episode such as a fibrillary reaction, when compared with a sustained one, like the tension state which may develop into chronic expression of cholinokinesis, reveals differences which perhaps are quantitative only.

While the discussion is limited to acute cholinokinetic episodes, mention must be made in passing of the intriguing vista opened by a glance into the field of chronic cholinokinetic episodes. As the preliminary scaffolding of the bridge that spans the arbitrary gap between "acute" and "chronic" cholinokinetic phenomena, an analysis will be made of recent progress in the elucidation of the mechanism of (A5) the tetanic reactions, the biochemistry of these reactions and their intrinsic nature as cholinokinetic phenomena. The constructed interrelationship of these phenomena will then permit an enumeration of a large group of protean clinical manifestations which can be considered to be conditioned by, accompanied by, or intrinsically cholinokinetic (Table II).

CHOLINOKINETIC NATURE OF TETANY REACTIONS

Tetany, though numerically the least frequent of observed reactions, is chosen for the exposition of the underlying cholinokinetic ubiquity of "shock" reactions in general. This is done because the (I) mechanisms of the tetany, the metabolic changes conducive to it, and its unique position as a predominantly somatomotor phenomenon in which the (II) activity of the choline ester—cholinesterase mechanism is exemplified, has been elucidated by laboratory and clinical data to a greater extent than that of any other

TABLE II
Clinical Conditions Based on or Attended by Cholinokinetic Reactions

Epileptoid-Syncope	Atopic-Exudative	Fibrillary-Pyrogenic-Tetanic
Epilepsies Acute Infections (in Children) Surgical Shock Heat Stroke Heat Exhaustion Motion Sickness Insolation Electric Shock Myasthenia Gravis Morphine Withdrawal Barbital Withdrawal ⁴²	Allergies Rheumatoid Arthritis Periarteritis Nodosa Pyogenic Infections Angioneurotic Edema Spasmophilia	Hyperthyroidism Malaria Pyogenic Infections Leucoses Pel-Ebstein Lymphomatosis "Psychogenic" Tension States Morphine Withdrawal

cholinokinetic condition. Part of this elucidation has come from an antithetical condition (III), myasthenia gravis, whose exposition is important in the concept of shock, for in clinical considerations, not only must the inciting and sustaining effectors of cholinokinetic state be understood but also the (IV) reacting mechanisms by which the body attempts to neutralize, abrogate or vitiate these states. Such compensatory mechanisms are existent and operative against all forms of cholinokinesis, and it is their operation which should be permitted to proceed unhindered in the therapy of these states.

I. MECHANISMS OF THE TETANY

Tetany is the result of an increased somatic neuro-muscular irritability resulting either from hypocalcemia, hyperphosphatemia, hyperinsulinism or hypoglycemia (some of the convulsions of insulin "shock" appear to be due to systemically elaborated acetylcholine like substances from the brain stimulated to hyperexcitability by the deprivation of glucose), intoxication by guanidine derivatives (powerful cholinokinetic drugs) and by alkalosis. The relationship of tetany to the other cholinokinetic episodes enumerated is exemplified by the ordinary occurrence of "autonomic" phenomena such as intestinal hypermotility, vagal bradycardia and bronchiolar constriction during the spasm. Its relationship to the epileptoid-syncope syndrome is evident in studies made on blood donor reactors; reactions of a mixed tetany-syncope type being not uncommon and Arenstam believes hyperventilation alkalosis to be the actual conditioning factor in the epileptoid syncope reaction.

Tetany likewise stands in close relationship to the visceral allergies. Spasmophilia in children is regarded by many pediatricians as being atopic in origin and so treated. While the basis of the specific therapeutic effect of calcium in tetany or spasmophilia is understood, no adequate explanation has appeared for the occasional undeniably dramatic response of the allergic subject to calcium therapy. Hypocalcemia, as it exists in most instances of tetany has been shown experimentally to enhance the response of the

autonomic ganglia to acetylcholine¹⁷ therefore hypocalcemic spasmophilia is a "cholinergic" state. In latent tetany, hypocalcemia persists but the cholinokinetic manifestations are submerged presumably by the inauguration of compensatory metabolic processes; the patient who has undergone the transition from manifest to latent tetany has "desensitized" himself, as it were. Comparable physiologic adjustments are involved in all types of cholinokinesis and forms another nosologic linkage among them.

The latent form is converted into manifest tetany by the intrusion of any of the acute cholinokinetic episodes or by any of the other chronic cholinokinetic states. Convulsions may be precipitated in spasmophilic children by fever, infections, even though these be afebrile, by atopy or even by anxiety or fright. Thus the effect of the various cholinokinetics may be additive and the response of the reactor to an overtly contributed increment which exceeds the threshold for reactivity may be through any one or more of several modes of expression; the latter in turn being directed not by the overt trigger increment but by the combination of internal environmental factors that go to make up constitutional predisposition or diathesis (Table III).

TABLE III
The Composition of a Cholinergic Episode.

Cholinergic Incitants	Cholinergic Reactions
1. Psychogenic Factors and/or	1. Convulsions and/or
2. Microbiotic Products and/or	2. Syncope and/or
3. Allergens, Anaphylactogens and/or	3. Chills and Fever and/or
4. Endogenous Metabolites and/or	4. Tetany and/or
5. Endocrine Imbalances and/or	5. Atopy and/or
6. Physical Trauma, Hemorrhage and/or	6. Heparinemic Extravasation and/or
7. Irradiation and/or	7. Hemopoiesis Suppression and/or
8. Drug "idiosyncrasy."	8. Shock and Sudden Death.

Cholinokinesis likewise implies more than (1) the circulation of abnormal absolute quantities of cholinergic and cholinomimetic substances; it may also imply (2) a state of the internal environment capable of interaction and summation with (1) or being intrinsically self sufficient to

produce an overt clinical episode in the cholinokinetic category.

While the role of the parathyroids in the tetany mechanism is not discussed, attention is directed to the important position of the entire endocrine system in any consideration of cholinokinesis both as a component of the general internal environment and as a specific conditioner of cholinokinetic response. The intrusion of endocrine in the collation of factors precipitating a cholinergic episode is clinically recognized.

II. THE CHOLINE ESTER-ESTERASE SYSTEM

Dixon¹⁸ in the early part of the century made a remarkable prognostication that a substance closely related to muscarine would ultimately be shown to be the mediator of the parasympathetic (cranio-sacral) autonomic system in the same manner as an adrenalin-like substance mediated the sympathetic (thoraco-lumbar) system.¹⁹ Loewi's classic work in which the cholinokinetic hormone was demonstrated²⁰ and its strong similarity to acetylcholine fulfilled Dixon's prediction and that this substance was the mediator of all synaptic and myoneural functions; both somatic and splanchnic even, indirectly, those of the sympathetic system (by the stimulation of adrenalin production) is now fairly accepted. Acetylcholine was, then, a humoral agent of far greater valency than adrenalin but the classic work of Cannon²¹ dominated academic thought as to the supreme role of adrenalin in autonomic activity. Clinically this doctrine was never controlling because from converging independent trails of study, the special predisposition of the vagotonic to splanchnic dysfunction; the predominance of parasympatheticomimetic phenomena (fever, chills, sweating, increased capillary permeability) was too obvious. When psychosomatic diseases came into prominence, Alexander¹¹ implied that had Cannon used the human for his studies, the role of the sympathetics would have been found insignificant or negative.*

Increasing appreciation of the physiological role of acetylcholine came with a partial elucidation of its mechanism of operation; it was such a powerful initiator of synaptic, myoneural and neuroglandular response that unless some agency for its rapid and complete destruction

were at hand, the organism was bound to be in a state of profound intoxication. The destructive agency, cholinesterase, was found to exist most plentifully where anticipated—at the seats of ordinary production and utilization of acetylcholine—the gray matter of the nervous system and in muscle but it was also found in tissues having no nerves (neoplasms) and in blood. Nachmanson²³ who has studied the enzyme extensively, has made some very interesting calculations as to the speed with which it affects decomposition of acetylcholine. Many potent preparations of an enzyme that hydrolyzes acetylcholine, specifically, have been prepared.²⁴ Much that is clinically useful has emerged from the theory that a separate enzyme system existed for the modulation of humorally engendered neuromuscular activity—prostigmine was synthesized on the basis of its chemical similarity to esserine; a drug that specifically inactivated choline esterase and caused "parasympathetic" stimulation by allowing the acetylcholine to act unhampered. The treatment of myasthenia gravis, a condition that was presumed due to an overabundance of cholinesterase, either absolute or relative to a diminished acetylcholine production, by the administration of "cholinergics" (those drugs that antagonized the esterase and thus synergized the activity of the ester) was another fruitful outcome of this concept.

The acetylcholine-cholinesterase theory, however, is probably an over-simplification, needing much amendment and revision to reconcile it with recent progress. In most studies which have attempted to relegate properly the relationship of systemically occurring cholinesterase to cholinokinetic phenomena, the serum cholinesterase has been subject to punctilious evaluation; that of the erythrocytes which makes up the major fraction of the blood enzyme has been neglected. Much of the serum fraction is a pseudocholinesterase,²⁵ it hydrolyzes all esters and thus its effect on choline-ester may be purely coincidental. Ferriheme (hematin) has cholinesterase activity¹⁵ and its globin derivative, ferrihemoglobin (methemoglobin) we now know to be present, normally, in the erythrocyte. Ferric hemes are present in all cells as the oxidized component of the cytochrome system and in addition in the granules of neutrophils and eosinophiles,¹⁵ in the nervous system as "lipohemes" and in the ubiquitous catalase. Their account in cholinesterase activity has not been evaluated.

In fact, to carry the implications of the acetylcholine theory to its ultimate conclusion, there is just as much rationale to the position that the substance operates by the relinquishment of its potential energy of acetylation in the neuro-muscular reaction and that physiologically, specific cholinesterase activity may not be the

* This does not minimize the importance of Cannon's work or of the emergency theory of adrenalin secretion as applied to the mammal. His summary of the physiologic distinction between the sympathetic and parasympathetic divisions, the former being "like the loud and soft pedals modulating all notes together"—the para-sympathetic being "like the separate keys". The implication is against generalized discharge of the chemical mediator of the parasympathetic system. Goodman and Gilman²² reemphasize this difference in general discharge proclivity of the two divisions. This may be the case in lower animals under physiologic conditions, but from the author's point of view general parasympatheticomimetic discharge does occur in the human and, in the case of the syncope syndrome can be considered a physiologic event.³ Laughing and weeping represent a rather generalized cholinokinetic discharge peculiar to the human.

result of enzyme action but merely the reflection of the activity of the effector tissue in the transformation of the potential energy for its own use.

Whether or not "cholinesterase" is an artefact in that the enzymes isolated may play no actual role in the physiology of interneuronal, neuro-muscular or neuro-glandular transmission, that the heme pigments form a protective mechanism in pathologic states of cholinokineses can hardly be doubted for they combine with and antidote not only acetylcholine but many other cholinokinetic substances.²⁶ The therapeutic administration of "cholinesterase" first suggested in this connection² was later found to be effective in traumatic shock in the dog.²⁷

If the significance of "cholinesterase" is considered moot, the same is true of the identification of "acetylcholine" as the cholinokinetic substance found in the blood in tension states, in shock, infections, syncope from motion, sickness, and allergic reactions. In all of the enumerated conditions, the substances found have been characterized by biologic assay (viz. guinea pig uterus strip) and the various investigators concerned have been in no agreement about its identity, expressing rather unanimous opinion that its action is not identical with that of synthetic acetylcholine, though similar to it. The state of uncertainty is easily explained on two bases. First, even synthetic, "chemically pure" acetylcholine shows marked variability between different lots and sources.²⁸ Secondly, the pharmacologic effects of acetylcholine are not remarkably different than those observed after the administration of any other cholinokinetic; in fact, histamine, guanidine, peptones, ptomaines, carbimid, may elicit such strikingly similar effects in the same animal or subject as to preclude their differential identification by biologic means. This is in keeping with the formulation that the "cholinergics" can be characterized on the basis of a chemical common property characteristic of forming undissociated compounds with iron prophyryns; the differences between histidine, guanidine and carbimid being one of degree rather than nature.²⁹

The cholinomimetics also have, among themselves a common property of forming coordination compounds with ferriheme.¹⁵ Whether it be a cholinergic (a drug inactivating cholinesterase) or a cholinomimetic (duplicating the action of acetylcholine on the effector organ) the reaction to any cholinokinetic (stimulator of the parasympathetic nervous system) shows only a limited variability and the latter appears to be conditioned for the greater part only by the constitutional predisposition of the individual or organ to such stimulus. If this is begging the question, it is doing so with the question closer to fundamentality. It directs our attention to

the study of these constitutional predispositions for, pharmacologically, the answers do not appear forthcoming. Quinine and strychnine both "anti-cholinesterase" drugs, elicit totally different responses; either is useless in the treatment of myasthenia gravis—the practical identity of action of the cholinergic, histamine and the cholinomimetic, pilocarpine as well as the possible artificial nature of "cholinesterase" may nullify the distinction between the two categories of cholinokineses; the definite therapeutic value shared by guanidine, choline esters and the sympathetomimetic adrenalin and ephedrine in myasthenia gravis calls for reexamination of the veracity of our classification of the "autonomic" drugs and hormones.

III. MYASTHENIA GRAVIS

There has been postulated in this condition a deficiency of acetylcholine stimulation of the somatic muscles. On this basis, the classic anti-cholinesterase, and the supposedly antiesterase prostigmine and esserine have been prescribed with effect. Success has likewise attended the administration of ephedrine. Myasthenia gravis is brought into the discussion of cholinokinetic episodes because it illustrates one plane of the network of connections between such episodes. The shock phase of the epileptoid syncope syndrome is an evanescent counterpart of it.¹ A condition with muscular weakness and lymphadenopathy due to chronic allergy has recently been described.³⁰ The role of the thymus³¹ in the production of myasthenia gravis further indicates inquiry into the role of the endocrines in the modulation of the pattern that "autonomic" dysfunction will assume. Status lymphaticus in the syncope reactor has already been mentioned in connection with the manner in which such an episode, a teleologic response, may go too far.³ Other indications exist for lymphoid hyperplasia to represent a shock phenomenon—when "counter shock"—the compensatory mechanism supervenes,—the thymus undergoes involution.³² Von Pirquet and Shick³³ have described the concomitance of lymphoid involution and the recovery from acute atopy (serum sickness). Possibly myasthenia gravis represents a counterpart failure of compensation to the syncope syndrome in the same manner as the condition described by Randolph and Hettig³⁰ is either a failure to compensate for allergic shock or it may in itself be a cholinokinetic state inasmuch as various cholinergics have curariform effects and these may predominate in myasthenia gravis.³⁴

The compensatory mechanisms in cholinokinetic episodes in general are worthy of mention because, again, they illustrate the universality underlying these episodes, masked though this universality may be by the diverse response of differently constituted individuals.

From a humoral basis, these compensatory reactions appear designed to be rid of the excess circulating cholinokinetic hormone. The syncope reactor, by virtue of the nature of his reaction is put at physical rest. The epileptoid and tetanic reactors utilize the excess hormone or convert its potential energy into what would otherwise be useless somatomotor effects. The pyrogenic reactor utilizes the increased metabolic activity to destroy the pathogen ordinarily evoking this reaction as the immunity reactions which are concurrently developing neutralize its cholinokinetic products. The allergic reactor relies likewise on specific immunity mechanism, primarily, though it is possible that eosinophilia represents the elaboration and the carriage of a cellular cholinesterase. Where these compensatory reactions are adequate, the cholinokinetic episode has been an acute and evanescent one. It would be axiomatic that there exist, as well, conditions in which the compensatory mechanisms are inadequate; chronic cholinergic states whose elucidation would be equally fruitful of exploration.

DRUG IDIOSYNCRASY AND SUDDEN DEATH

No discussion of acute cholinokinetic episodes would be incomplete without inclusion of the most dramatic and tragic of all—sudden death of an apparently healthy individual after the administration or application of any one of the drugs in common use. For the purpose of formalization, we might include among the latter the classic anaphylactogens but in this connection, reference is made particularly to the non-biologics such as inhalation and local anesthetics. Convulsive episodes incident to the administration of ether,³⁵ or nitrous oxide³⁶ are appearing more frequently in the literature. An instance of sudden death immediately following topical pontocaine application preparatory to tonsillectomy was seen by the author. Cholinokinetic episodes induced or incidental to ether administration are understandable ("allergy" to ether has frequently occurred³⁷) because ether is a cholinergic drug and can be demonstrated to potentiate the action of acetylcholine in laboratory animals³⁸—in the case of pontocaine and the comparable one of cocaine (the frequent "idiosyncrasy" to which led to its abandonment in dental practice) we must presume that a cholinokinetic response is a reflection the tendency of the individual to amplify whatever cholinergic aspect either muscarinic, nicotinic or curariform that practically all drugs possess, at least to some extent.

The apparent increase as exemplified by recent reports of acute episodes, prescribes circumspection in the employment of powerful cholinokinetics in those individuals who appear to be prone to deleterious effects from cholinokinesis.

Newer therapeutic agents must be explored

from this angle before wholesale application is attempted. It is not generally appreciated that many of the components of the Vitamin B Complex are cholinergics³⁹—intravenous niacin therapy has been followed by a complete epileptoid-syncope syndrome and death (Ashworth⁴⁰). We must presume, however, that here again the drug administration has carried a preexisting high cholinokinetic level over the threshold and that elimination of such reactions will be accomplished more successfully, not by dogmatic avoidance of any category of drugs, but by the careful consideration of the patient and the elimination of other dispensable sources of cholinokinesis.

Since a large measure of the latter results from psychic stimulation, the amelioration of the latter through judicious barbiturate medication, has undoubtedly played a tremendous role in keeping cholinokinetic episodes at a minimum. Gebhardt⁴¹ states that they may practically be eradicated from dental practice (prolific source of these reactions) by prescription of nembutal as a routine in nervous individuals. He does not use the sedative universally, but is able to evaluate a patient, usually on inspection. We believe this to be possible from experience on blood donor subjects by the use of clinical appraisal. It is hoped, however, that the current studies on human constitutional types will permit the more exact characterization of those individuals in whom these episodes are prone to occur and thus lead to their elimination.

SUMMARY

Decision that psychogenic syncope (primary shock) as observed in blood donors, represented an acute cholinokinetic episode led to a study of syncope among typhoid vaccine reactors in the Armed Forces.

The second dose of killed typhoid bacilli may be followed by either convulsive, syncopic, atopic, fibrillary, pyrogenic or tetanic reactions.

From an analysis of the phenomena exhibited by typhoid vaccine reactors, it is evident that the various types of reaction are remarkably interrelated in the features of type of reaction, type of reactor, clinical counterpart, leading symptom, and the ability of known physiologically extant cholinokinetic substance that will produce identical symptoms on administration.

This correlation among five components of a system, however arbitrarily these components may seem to have been set up, indicates that the correlation could hardly be one of chance.

All typhoid vaccine reactions have an underlying ubiquity in that they are cholinokinetic phenomena.

The similarity of typhoid vaccine reactions to various "psychosomatic" phenomena, characterizes the latter, likewise, as cholinokinetic, the source of the cholinokinetic material in this instance being by exaggerated systemic elaboration.

tion of the normal cholinokinetic hormone of the nervous system. In this sense, the gray matter of that system may be regarded as an organ of internal secretion.

The diurnal cycle of temperature and metabolic activity is a reflection of the cycle of cholinokinetic hormone production; a reinforcement of this cycle by extra-neural sources of cholinokinetic material amplifying the cyclic excursions. In this manner, pyrogenic episodes and hectic fevers are explained.

An attempt is made to characterize the substances systemically extant or increased in cholinokinesis. The present pharmacologic classification of automatically active drugs is inadequate and it is concluded that cholinokinesis is induced or sustained by a wide variety of physiologically occurring chemical entities, acting singly or in combination, and evoking an effector response, the type which is conditioned to a greater extent by the constitution of the reacting individual or organ than to the type of hormone or drug extant. The clinical interdigitations of etiologic, symptomatologic and therapeutic aspects of the various cholinokinetic reactions and states forms a nosologic basis for their consideration as a specific category.

Possible transition between acute cholinokinetic episodes and chronic cholinokinetic states are found when a list of clinical conditions, characterized by cholinokinetic phenomena is drawn. The essential underlying etiologic ubiquity of the epileptoid-syncope, the atopic-exudate, the fibrillary-pyrogenic and the tetanic episodes is then apparent. The unsuitability of our present classification of "autonomic" drugs into adrenergic and cholinergic is indicated by the fact that the reaction of any drug in this category is predominantly dependent on the reactivity of the human to whom it is administered.

Choline-esterase is probably a property of the biologic media by virtue of which the potential energy of cholinokinetic substances is translated to kinetic energy of inter-neuronal, neuro-muscular or neuro-glandular reaction, rather than a specific enzyme. Choline esterase activity in neutralizing the cholinokinetic effects of certain drugs, while an accidental property, is nevertheless a useful protective mechanism against the noxious effects of cholinokinesis.

Any form of profound or protracted cholinokinesis, whatever its manifestations, is the essential incitant of "shock" and sudden death may be an incursion in any cholinergic episode.

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Streptococcal Infections and Scarlet Fever

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CONFUSION and misunderstanding still exist relative to present-day thinking with regard to control measures involving the large group of streptococcal infections and particularly scarlet fever. The present article attempts to clarify this situation and promote the use of uniform procedures throughout the State. This will in the final analysis be most beneficial to the patient with scarlet fever, his family, and the community.

Amidst many changes in a changing world, modern public health practice has modified its opinions concerning the best methods of limiting the spread of communicable diseases. There is a large body of factual evidence, the result of much study and research, which tends to discredit former attempts to control communicable diseases by means of the application of rigid methods of quarantine regulations. It is now realized that the time and efforts of public health personnel can be used far more effectively in the promotion of approved methods of prevention, rather than acting as so-called police officers in attempting to prevent infractions against authority. Dr. Haven Emerson, speaking at the University of Michigan in 1948, stated it concisely and well . . . "today we are moving from the application of authority toward the application of understanding and cooperation—persuasion through education."

In keeping with this modern trend in thinking, many state health departments have greatly limited the number of communicable diseases which require strict isolation and quarantine regulations for the control of contacts. In fact, in some states only two major communicable diseases are so regulated, namely, diphtheria and smallpox. Toward many of the other communicable diseases, the attitude of health departments has grown steadily more liberal, with less and less restriction of the family and of other contacts of the patient. An accumulation of evidence bears out the fact that former methods of rigid control have done little or nothing toward limiting the morbidity of those diseases in which attempts were made to apply them.

The American Public Health Association has recommended a changed attitude toward the great group of streptococcal infections and one of them in particular, scarlet fever. In the past, a diagnosis of scarlet fever gave rise to the well-known procedures formerly followed, including strict quarantine of the home and all

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contacts for periods varying from 21 to 28 days, or even longer.

Health authorities now know that such restrictions have had little effect in limiting the number of scarlet fever cases which arise in any given community. Morbidity figures concerning scarlet fever incidence remain practically constant throughout the years while, at the same time, mortality rates from the disease have gone steadily and gratifyingly downward. Three things may account for this fact: (1) Perhaps we are confronted today with a milder form of the disease than existed formerly; (2) perhaps there is a higher degree of individual immunity; and (3) better methods of treatment are available with chemotherapeutic and antibiotic agents. Aside from the benefit to the patient himself by isolation from others, to prevent cross-infection, strict control of the contacts has not limited the number of streptococcal infections to any great degree.

Scientific research into the characteristics of the streptococci in general has revealed that scarlet fever is not a clinical entity in itself. It is but a symptom complex indicative of one individual's response to the beta-hemolytic streptococcus which produces an erythrogenic toxin to which this particular individual is sensitive and hence responds with the characteristic scarlet fever rash. Simultaneously, other individuals in the same household or community, infected with the same organism but not sensitive to erythrogenic toxin, do not develop the rash and are therefore not diagnosed as scarlet fever. They are, however, quite as capable of transmitting the infection as the typical scarlet fever case. It seems quite illogical, therefore, to isolate and impose restrictions upon the individual who happens to have the rash, and do little or nothing about the individual who is not so affected. Dr. John Dingle, professor of preventive medicine at Western Reserve University, Cleveland, has aptly defined this situa-

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tion as follows: "The cases themselves may not be the most important sources of infection since they are frequently greatly outnumbered by carriers. The finding of all cases and especially all carriers would be a tremendous, if not impossible, job for the epidemiologist and for the laboratory. Since, under certain circumstances, carriers alone may number 20 to 30 per cent of the population, isolation and quarantine become almost impossible."

In view of the following circumstances:—

(1) newer knowledge concerning scarlet fever and the streptococci; (2) scarlet fever apparently milder in form than the disease which was formerly prevalent; (3) perhaps greater individual immunity; (4) better means of treating cases; (5) fewer and less severe complications; (6) the realization that former methods of strict control have been of little or no benefit—the Ohio Department of Health now recommends the isolation of scarlet fever patients only until the clinical symptoms have cleared, and this is usually terminated in fourteen days or less. Should individual cases require longer periods of isolation, this can be determined by the physician in cooperation with the local health officer.

Restrictions of family and other contacts—that is, quarantine—is not recommended as a routine procedure. It should be imposed only in cases where there is no understanding or cooperation in regard to isolation of the patient; or where an unusual epidemiological hazard exists. Section 4429, Ohio General Code, indicates that homes where scarlet fever develops must be placarded, but establishes no definite period of time for the placard to remain posted, this being left to the discretion of the local board of health. It also "prohibit(s) entrance to or exit from such house without written permission from the board of health." These stipulations of the law should be satisfied on the first epidemiological visit to the case.

SUMMARY

In order to promote state-wide uniformity in reporting and controlling streptococcal infections, particularly scarlet fever, the Ohio Department of Health recommends that the following rules be kept in mind:

1. Isolation of the patient until clinically well—usually accomplished in fourteen days or less; recommended for benefit to the patient himself.

2. Quarantine of contacts in the family and otherwise, is not recommended unless some unusual circumstances are existent.

3. Requirements of the Ohio General Code should be satisfied.

4. More effort should be made to determine and report the existence of other streptococcal

upper respiratory infections, i.e., those cases that do not develop the rash typical of scarlet fever.

If Ohio physicians and local health departments present uniform interpretation of regulations concerning control of scarlet fever and other streptococcal infections, the public will come to a clearer understanding of the disease and a more reasonable and cooperative attitude will result.

The Allergic Child

If a definite relationship can be established between the allergic symptoms and certain foods, not only by means of skin tests but by actual clinical trial, such foods should obviously be eliminated or so modified as to be non-allergic. Milk, eggs, wheat, nuts, all have their place in the production of asthma. Our experience with superheated evaporated milk in cow's milk allergies has been quite satisfactory and we find that it is the simplest means of combating a milk allergy. In some instances soy bean preparations or goat's milk must be used. It is important to note that in older children, in particular, one must take into consideration the clinical importance of foods before eliminating them from the diet and perhaps causing a nutritional deficiency. We are all familiar with the patient who says, "Oh, I showed positive tests to everything; what am I to eat?" An example of such a case is a 15-year-old boy who has had allergic manifestations since infancy. At present he has occasional attacks of mild asthma which can be kept under control by means of ephedrine preparations. About a year ago a series of skin tests revealed positive reactions to almost all of the ordinary foods. It would be futile to attempt to treat this patient on the basis of skin tests. Clinically, his asthma develops only after taking egg and most of his attacks are probably due to inhalants. We must remember to treat the patient and not the skin tests.

EXERCISE

We see no reason why these patients cannot be permitted to engage in normal activities and sports just like any normal child.

Respiratory infections certainly play an important part in precipitating asthmatic attacks. Consequently, climatic changes are sometimes helpful. However, one must remember that dust allergies occur in the most favorable climates and that some of the so-called asthma resorts really have a very luxurious growth of pollen-bearing grasses and weeds. Certainly for the asthma which is chiefly infectious in nature a high dry climate is beneficial.—Hyman A. Slesinger, M.D., Windber, Pa. Pa. Med. Jr., Vol. 51, No. 9, June, 1948.

Amebic Abscess in a Student Veteran: Report of a Case

FRANK R. MOORE, M.D., and E. HERNDON HUDSON, M.D.

LIVER abscess of amebic origin has been traditionally associated with the tropics. With the return of veterans with amebic infections acquired in warm and unsanitated countries, the incidence of liver abscess in this country is bound to rise. Diagnosis is admittedly difficult, and unfortunately is often made after instead of before surgery is undertaken. The following case is presented to illustrate some of the pitfalls of diagnosis and factors involved in proper management.

CASE REPORT

A white male college student, 23 years of age, was admitted to the infirmary on September 22, 1947, complaining of difficulty in breathing and a "cold" of one day's duration.

He was a Navy veteran, having served in the Philippines and other parts of the Pacific Theatre in 1944 and 1945. His only illnesses during this period of duty were several bouts of diarrhea which were promptly relieved by symptomatic and ambulatory treatment. No attempt had been made to determine their cause, and the patient himself was so little concerned with them that he only recalled them after particular questioning late in the present illness. He was discharged from the Navy without disability in December, 1945.

Present illness: On the day before admission, he had had "chilly feelings" and the onset of a "cold" with slight sore throat, cough and wheezing.

Physical examination: The patient appeared acutely ill, with flushed skin, profuse perspiration, and obvious respiratory discomfort. His temperature was 101° F. (38.3° C.) The upper respiratory tract was congested, and there were dry rales throughout the right lower lobe. The abdomen was not remarkable.

Course in hospital: Symptomatic treatment for the upper respiratory infection was instituted, but on the second hospital day his temperature rose to 103.2° F. (39.5° C.), and he had a violent chill lasting about a half-hour. His white blood cell count was 16,400. He was given penicillin intramuscularly, 20,000 units every three hours, but 300,000 units during the next two and a half days failed to alter his course, chills recurring daily and the temperature fluctuating around 102° F. (39° C.) Sulfadiazine was therefore substituted for penicillin but he did not tolerate it well and the drug was discontinued after 24 hours, when 9 grams had been given. At this time the white blood cells dropped to 13,800, and the chest signs had cleared somewhat.

Pain in the right costo-vertebral angle was first noted on the fifth hospital day, and there was tenderness to percussion over this area. On the seventh hospital day, his chills became more frequent and the temperature again rose above

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103°; on the eighth day his white blood cell count was 21,250. A blood culture at this time was negative, and chest X-rays failed to show pneumonia. In fact, the chest signs further cleared with administration of streptomycin which was started on the eighth day. On the tenth day, he began having pain over his liver as well as in the right costo-vertebral angle. The liver edge was palpable three finger-breadths below the costal margin, and became very tender. An X-ray of the abdomen verified the enlarged liver, but absence of psoas shadow on the right posed the problem of differential diagnosis between liver abscess and a retroperitoneal mass.

However, the patient at this time informed us that his bowels had been "loose" for three days. He had felt that this was natural and inconsequential since he had been eating no solid food. Search for intestinal parasites revealed amebic cysts on the thirteenth hospital day.

He was immediately given emetine hydrochloride hypodermically at the rate of one-half grain (0.032 G.) thrice daily. This dosage was maintained for two days, then dropped to twice daily for five more days. Thus in one week he received a total of eight grains (0.5 G.). One gram of Carbarsone was given daily for a week, starting on the fifteenth hospital day. On this medication, he rapidly improved. The temperature dropped precipitously, ceased to fluctuate, and reached normal on the eighteenth day of hospitalization. On the nineteenth day of admission he was allowed to go home at his own request and was given Vioform sufficient for one gram daily for one week. His only residual symptom was a rather constant dull pain in the right shoulder.

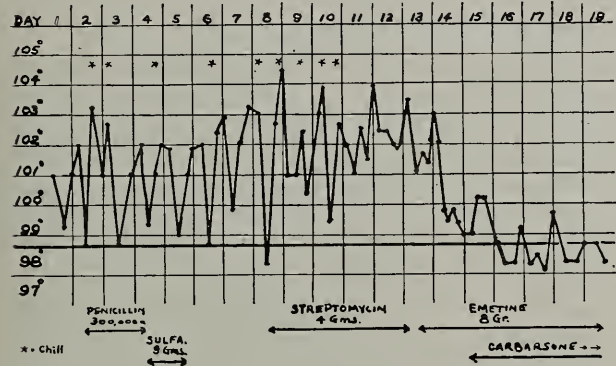
When he was seen two weeks later he had no symptoms, and was regaining his weight.

COMMENT

It is useful to distinguish amebic dysentery from amebiasis, which is the broader term. Dysentery may never be present in a case of amebiasis, or may be so mild and transient as to be unrecognized. The patient left the Philip-

pinus three years ago. It is possible that he may have acquired amebiasis since his return, but it is more likely that he got his infection abroad. Such patients may remain in a clinically latent state, apparently in perfect health but passing cysts for many years. In one reported case the latent interval was 20 years. It is generally assumed that there is some precipitating factor which converts a latent into a clinical case, but none could be identified in our patient, unless it be that his acute upper respiratory virus infection in some way acted unfavorably on a hepatitis and encouraged the formation of an abscess.

The favorite site of amebic ulceration is in the cecum and ascending colon; thence it is the portal drainage that carries the infected material to the liver, more to the right lobe and more to the dome. There is first a hepatitis, and



then multiple small separate abscesses which may coalesce later. There is no clear line of distinction between a hepatitis and an abscess. The liver becomes palpable and tender, the diaphragm stationary in a high position and flattened. There is pain referred to the right shoulder, as in this case, and a high leucocytosis, with fever and sweating. There is usually chilliness but not so much rigor as our patient exhibited. The patient is not jaundiced but the sclerae are usually icteroid. Our patient had a low icteric index. In amebic abscess the stool is found to contain cysts or trophozoites in about half the cases.

In the formation of an abscess there is necrosis of liver tissue, and this is sometimes followed by secondary infection. The contents are of a viscid consistency and a chocolate brown color. As the abscess increases in size, the patient feels as if he were carrying a weight in his right side and the chest eventually becomes asymmetrical, with bulging in the right axillary line. There is little difficulty in diagnosing such an advanced case, but there is often such a variation in the number and severity of symptoms that the correct diagnosis is overlooked or delayed, as in our own case. A so-called "silent" abscess should always be kept in mind when signs point to the right upper quadrant. Manson-

Bahr says, "Of all tropical diseases, none is so often overlooked as abscess of the liver."

In the differential diagnosis the chief confusion is with malaria, especially in the areas where malaria and amebiasis are both prevalent. The most frequent mistake in treatment is to "drench the patient with quinine." Other conditions which must be differentiated include: pylephlebitis from a suppurative appendix, perinephritic or retroperitoneal abscess, and subphrenic abscess from a ruptured viscus.

The conventional treatment for amebic abscess is emetine and aspiration. Full trial of emetine should be made no matter how large the abscess seems, as experience has shown that this drug will reduce the size of even the largest abscesses, and often abolish surprisingly large ones. Dangers accompanying the use of emetine have been greatly exaggerated and should be disregarded when the dangers of surgical incision constitute the alternative. Aspiration should follow closely after emetine in those abscesses which do not respond entirely to emetine alone. Surgical incision of an amebic abscess is seldom justified. This is so contrary to the practice of surgeons dealing with abscesses ordinarily met with in this country that many operate on amebic abscesses first and diagnose them later. There is full statistical support for the priority of emetine and aspiration over surgical incision. Drainage through a hollow needle has had a definitely lower mortality than drainage through an incision, and though modern equipment and incidental medication have reduced the risks, it remains poor surgery to cut into an amebic abscess.

ADDENDUM

March, 1948: The patient was examined at this time. He felt perfectly well, and the examination was negative except for a marked increase of weight to 185 pounds.

SUMMARY

1. The case report of a student veteran suffering from a hepatic abscess of amebic origin is presented. It is recalled that this condition may be easily overlooked, and should always be considered in the differential diagnosis of obscure signs and symptoms in the right thorax or abdomen.
2. Penicillin, sulfadiazine, and streptomycin were all ineffective in our patient. This is perhaps the first trial of streptomycin in amebiasis. Emetine as usual was promptly effective.
3. Liver abscess of amebic origin is not ordinarily a surgical condition. The surgeon on incising an undiagnosed liver abscess is not justified in saying it would have had to be opened anyway. Such cases should with rare exceptions remain in the medical ward and be treated by the internist.

Report of Four Cases of Granuloma Inguinale Treated With Streptomycin

LESTER M. MASON, M.D., and ASHTON L. WELSH, M.D.

THE recent work at the University of Georgia¹ and of Barton, et al.,² indicated that streptomycin was an efficient therapeutic agent in patients who had granuloma inguinale. Three additional recent reports confirm those just mentioned.^{3, 4, 5} This communication is a report of four patients so treated; two of which were resistant to repeated courses of antimonial drugs over a period of several years.

REPORT OF CASES

Case 1.—O.D., a Negro man, aged 30, was admitted to the hospital on September 16, 1946. This was the sixth time this patient had been admitted to this hospital since the onset of his illness in 1937. The diagnosis of granuloma inguinale was made and proved on each of these admissions. Altogether, he had been hospitalized approximately four years of this nine-year period. He had received antimony compounds almost continually, throughout his illness, except for short periods of time in which he showed toxic reactions to the drug.

Examination revealed a poorly nourished and poorly developed colored male with large vegetating lesions the size of his palms, involving the inguinal regions and extending over the genitalia and perineum. The patient continued to receive antimonial drugs for nine months. At the end of that time, large open lesions were still present from which Donovan bodies were demonstrated. He was then given 250 mgs. of streptomycin intramuscularly every three hours until he had received a total of 40 gms. His lesions showed an immediate response and all lesions were healed twenty-nine days after streptomycin therapy was begun. When he was discharged, scrapings from the lesions did not reveal Donovan bodies. The patient has been seen regularly in the out-patient department since then and there is, to date, no evidence of recurrence.

Case 2.—J.M., a Negro woman, aged 56, had been treated in the hospital and dispensary for the past two years for proved granuloma inguinale. The previous treatment consisted of alternating courses of tartar emetic and Fuadin. She was admitted to the hospital June 17, 1947, because of several large ulcers about the vulva and perineum. Scrapings from these lesions showed Donovan bodies. She received 250 mgs. of streptomycin intramuscularly every three hours for a total of 28 gms. At the end of this therapy, all lesions had healed and have remained healed to the time of this report.

Case 3.—D.W., a Negro woman, aged 38, gave a history of menorrhagia of four months' duration and inguinal ulcers of one month duration. A biopsy of the enlarged boggy cervix showed Donovan bodies in the large mononuclear cells. These bodies were also seen in tissue scrapings from the inguinal ulcers. She was given 250 mgs. of streptomycin intramuscularly every three hours for a total of 56 gms. The cervical bleeding ceased shortly after treatment was instituted

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and the inguinal lesions began to heal. When treatment was discontinued the inguinal ulcers were not completely healed, but Donovan bodies could not be demonstrated. The lesions continued to heal, without further therapy and five months after discharge, inspection revealed all of the lesions to be healed.

Case 4.—S.M., a Negro woman, aged 29, was admitted to the hospital in June, 1947. Examination revealed large ulcerating lesions about the vulva and gluteal folds. They had been present for ten years. Scrapings from the ulcers showed Donovan bodies. She was given 250 mgs. of streptomycin intramuscularly every three hours for a total of 22 gms. At the end of this treatment all lesions were healed. When last seen four months after discharge, there was no evidence of relapse.

CONCLUSION

Four patients presenting clinical and laboratory evidence of granuloma inguinale were treated with streptomycin. Two of these patients had been treated with antimonial compounds for long periods of time without success. All of these patients showed a dramatic response to streptomycin therapy. It is believed that streptomycin is currently the drug of choice in the treatment of granuloma inguinale.

ADDENDUM

Since this report was compiled five additional patients with granuloma inguinale have been successfully treated with streptomycin in this hospital.

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Ovarian Disgerminoma With a Report of Two Cases

JOHN A. SPENCER, M. D., and PHILIP J. REEL, M. D.

THERE have been, at the present time, something over 200 cases of ovarian disgerminoma reported. Therefore, although this tumor is no longer considered a rarity, it seems to us that additional cases are worth reporting and adding to the literature.

The disgerminoma represents from one to three per cent of all ovarian neoplasms^{3,4} and is usually a tumor of childhood and early sexual life. One-third of the cases occur in childhood and 70 per cent appear before the age of thirty; the oldest case recorded was 52.

Histogenetically this tumor probably arises as the result of an error in differentiation of the cells of the mesenchymal core of the developing ovary.¹ R. Meyer, who first suggested the name, felt that the neoplasm originated from "neutral disgerminal cells" found in the mesenchyme of the gonads before the stage of sexual differentiation.² Others feel that there is a teratomatous precursor.⁵ It has been our feeling that an origin from the mesenchymal core of the ovary is the most likely.⁶

Clinically there has been noted a very frequent, though not invariable, association of this tumor with various forms of hypogonadism—from the oligomenorrheic, flat-chested asthenic type through the gamut to the true hermaphrodite. The majority of reported cases have occurred in hypogonadal individuals.^{2, 7, 8, 9, 10, 11} This frequent association with various degrees of ovarian hypofunction is compatible with the neutral type of tissue composing the tumor; it is, however, an expression of the agenesis of the gonadal system in these patients prior to tumor development as feminization does not follow removal of the neoplasm. Whether the disgerminoma occurs in a normal or hypogonadal type seems of little prognostic significance, but according to Barzilai the degree of malignancy of the new growth parallels the degree of imperfection of the sexual characteristics of the patient; the tumor being less malignant in patients with normal sexual development.¹²

Hohage explains the frequent occurrence of this tumor in young people and adolescents on the basis of the hormonal impulse given to the ovaries at this time of life, which impulse is transferred to the latent tumor cells and stimulates them to growth.¹⁰ Several authors have found that the output of gonadotrophic hormone is low or within normal limits.^{2, 10} Others are in general disagreement as to the status of hormone studies.^{12, 7, 11, 13} It appears to us that there is

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probably an occasional case which will excrete sufficient hormone to give a positive A-Z test, but that it is most frequently negative in the presence of this tumor and has no diagnostic significance.

The majority of these neoplasms are unilateral and estimates of malignancy vary from 10 to 68 per cent.^{2, 8, 14, 15} Barzilai states that the tumor is undoubtedly malignant, but the degree is variable and must be considered as less than that of a carcinoma or sarcoma.¹² Histologically almost all of these tumors show malignant features, as would be expected from their histogenetic background.

Although conservative surgery is advocated by R. Meyer and others, the majority of authors advocate radical extirpation.^{3, 12, 13} Since we are frequently dealing with children and young adults, the tendency for conservatism is strong. However, since the tumor is so frequently encountered with some degree of hermaphroditism the radical approach, even in unilateral growths, is often the one of choice. The use of postoperative roentgen radiation has not been universally accepted, but several authors report good results and prolongation of life by the use of radiation to growths that had already metastasized at the time of operation. Others note that these tumors are extremely radiosensitive.^{12, 16} Whether conservative treatment is justifiable or not is an individual matter. With a unilateral, encapsulated, freely movable tumor in an otherwise normal young adult without children, merely local removal would be safe in the majority of cases. With the same condition occurring in a moderate to marked hypogonadal patient, radical treatment should be carried out. Bilateral tumors, and those showing extension, should receive radi-

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cal surgical extirpation and this followed by intensive deep roentgen therapy.

Our two cases of disgerminoma represent 0.98 per cent of our total ovarian neoplasms over the past fifteen years. Both cases were in children and both showed extension at operation, in one so advanced as to make removal of the tumor impossible.

CASE NO. 381405

A thirteen-year-old white female was admitted in 1938 complaining of vaginal bleeding of six weeks duration. Her periods had started at the age of twelve and normally lasted four to five days with a 28-day interval. They had always been normal and regular until the onset of her present flow. She had lost considerable weight, complained of headache, weakness, dizziness, and pain in both legs.

Physical examination: Negative except for evidence of anemia, a liver margin palpable one finger breadth below the right costal margin and a hard, fixed tumor mass filling the pelvis and extending superiorly to the umbilicus. Vaginal bleeding was mild to moderate in amount. External genitalia were normally developed, as were the breasts.

Laboratory: Hemoglobin 38 per cent, red blood count 2.16 million, white blood count 15,750 with 64 per cent polymorphonuclear neutrophil leukocytes. Sedimentation rate slightly elevated. Urine, Kahn and phenolsulfonphthalein tests were normal. Abdomino-pelvic X-ray was negative. Friedman was negative.

Operation: D & C and exploratory laparotomy. "The uterine cavity was elongated and slightly larger than normal. Endometrium presented no gross abnormality. Upon opening the abdomen, massive intestinal adhesions permitted only a very small area of the tumor to be exposed. A small block biopsy was removed with the cautery and revealed a milky, white, semi-liquid substance exuding from the tumor."

Pathology report: Atrophic endometrial tissue, which presented slight manifestations of lutein stimulation. The biopsy block revealed a disgerminoma, histologically highly malignant.

Postoperative course: The patient received a total of 2,000 roentgen units beginning one week after surgery. At the conclusion of therapy the tumor mass had shrunk to less than half its previous size. Six weeks after leaving the hospital the patient died of her disease.

CASE NO. 416675

A fourteen-year-old white female was admitted in August, 1941, complaining only of progressive enlargement of her abdomen for the previous four months and a loss of twenty pounds in weight. For the previous three months she had had shooting right lower quadrant pains; and for two months had suffered from dull frontal headaches. She had never menstruated. About one year before entry her breasts began to enlarge, but in the several months prior to admission they had become smaller.

Physical examination: Negative except for a palpable, solid abdominal and pelvic tumor mass which was fixed, non-tender and extended six centimeters above the umbilicus. The external genitalia showed normal hair distribution; the clitoris and labia were within normal limits.

The breasts were poorly developed and the uterus was not palpable.

Laboratory: Hemoglobin 13 grams, red blood count 5.02 million, white blood count 6,600. Urine contained 5 grams of albumin/liter. Kahn was negative, BUN 43, sedimentation rate slightly increased. Vaginal smears showed no estrogen response, Friedman test was negative. X-rays of chest and abdomen were negative. I. V. pyelograms showed lateral displacement of the left ureter.

Operation: Laparotomy: "There was a solid, nodular tumor mass extending above the costal margin and impacted into the bony pelvis, compressing the uterus anteriorly. The tumor presented numerous areas of softening, and was densely bound to the posterior and posterolateral pelvic walls with the omentum adherent to the right side and the sigmoid mesentery to the left side. The tumor arose from the left ovary; the right ovary was somewhat enlarged, but otherwise grossly normal. Bilateral salpingo-oophorectomy and supravaginal hysterectomy were carried out after a frozen section diagnosis of disgerminoma."

Pathology report: The tumor weighed 2,000 grams and was 22 x 11 x 10 cm. It was composed of solid, friable hemorrhagic tumor tissue. The opposite ovary presented multiple simple cysts. A small uterus is grossly normal. Microscopically the tumor is a disgerminoma of malignant type.

Postoperative course: The patient received a total of 2,400 roentgen units, beginning one week after operation. Her course was uneventful and she was discharged improved. She has been periodically rechecked and at the time of her last visit, September, 1946, five years after operation, she was well and showed no evidence of disease.

SUMMARY

1. A brief clinical resumé of disgerminoma is presented.
2. Two cases of disgerminoma are reported and briefly discussed.

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Bilateral Ovarian Dermoid Cysts Complicating Pregnancy

HYATT REITMAN, M.D.

INTEREST in this rare obstetrical complication was stimulated by a personally observed case. Bilateral dermoids complicating pregnancy in which bilateral oophorectomy is performed are of particular interest because of their rarity. The available literature reveals only 57 reported cases. C. J. Andrews and colleagues, in a thorough review of the literature in March, 1940, found 43 cases and reported a case of their own. Since that time, Bowles has reported five cases, and King, Southward, Doyle-Daversa, DeLee, Goodwin, Ramos and Columbo, Ellis, and Nucci have each added a case to the literature.

CASE REPORT

Mrs. E. G., aged 33 years, was seen on December 29, 1944, and stated that the onset of her last menstrual period was on October 23, 1944. She complained of much nausea and occasional vomiting. Past menstrual history was completely negative. She had been delivered of a male child in November, 1934, with an uneventful pregnancy and delivery. In May, 1944, there was a spontaneous abortion of a six weeks' pregnancy and another questionable abortion a few months previous to this. She had anterior poliomyelitis at six months of age which primarily involved the right leg. Family history was noncontributory. General physical examination was negative except for moderate atrophy of the muscles of the lower right leg with a moderate limp. Pelvic examination showed a marital outlet, with the uterus the size of a six weeks' pregnancy, soft, and in the normal anterior position. There was a moderate size fibroid (?) at the left cornua of the uterus. Adnexae apparently negative.

On February 9, 1945, the patient developed a severe constant pain in the right lower quadrant which radiated medially toward the pubis, accompanied by slight nausea and the patient was hospitalized. Examination revealed a soft abdomen, a uterus the size of a three months' pregnancy, and a questionable mass felt in the right lower quadrant. Temperature 37.3, pulse 100, respirations 22. An X-ray was taken on admission with the following report: "The pelvis is of rather uniform density. There is a shadow of a fetal skeleton possibly not over four months old. There is an area of increased density in the right mid-abdomen which extends from about two inches above to possibly two and one-half inches below the crest of the ilium. The lower part of it seems to contain teeth and other bony structures. This is possibly due to a dermoid cyst. There is a circular area of varying density in the left mid-abdomen which is almost as large as the one on the right side. There is a shadow of a small, dense, object along its lateral border. This could represent material in the intestine. This is, we believe, a second tumor, possibly of the same type as the one on the right side. The patient is in addition pregnant."

Submitted April 27, 1948.

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A diagnosis of bilateral dermoid ovarian cysts with possible torsion of the right pedicle was made. The patient was placed on a strict peritonitis regime with intravenous glucose, icebag to the abdomen, morphine sulphate and codeine for pain. Blood count made on February 10, 1945, was reported as follows: Leukocytes 8000, hemoglobin 13.6 gms. Urinalysis negative.

There was no relief of symptoms and on February 11, 1945, a laparotomy was done. A bilateral oophorectomy and right salpingectomy were performed. Upon opening the peritoneum, a moderate amount of cloudy free fluid was found in the abdominal cavity. The undisturbed enlarged (three months) uterus contained an apparently normal intrauterine pregnancy. The dermoid cyst of the right ovary was 9 cms. in diameter, hemorrhagic in appearance with moderate torsion of the pedicle. The right tube was adherent to this mass. The left dermoid cyst was 8 cms. in diameter, non-adherent, with no normal ovarian tissue seen. The pathologic report read: (1) Dermoid cysts of both ovaries with hemorrhagic infarction of right tube and ovary; (2) two accessory branches of right tube. In one of the sections of the right ovary, a portion of a large organized corpus luteum could be recognized in spite of the infarction.

The patient's postoperative course was entirely uneventful except for some moderate abdominal cramping. The patient was given large doses of progesterone hypodermically during her hospital stay. There were no signs of threatened abortion at any time during this stay. She was discharged on the fourteenth postoperative day in good condition and placed on oral progesterone therapy for the next month. Her prenatal course until delivery on August 3, 1945, was uneventful. At no time did the patient demonstrate any signs or symptoms of threatened abortion or threatened premature labor. She was delivered by low forceps of a living female child in a left occipito-anterior position with a prolapsed left (posterior) hand. The puerperium was uneventful and mother and baby were discharged on the tenth day.

The routine postpartum examination on September 15, 1945, was essentially negative. Subsequent follow-up reveals an amenorrhea since her delivery without any menopausal symptoms to date.

DISCUSSION

Possible complications of bilateral dermoid cysts have led to a more or less general agreement among obstetricians that the cysts should

be removed during pregnancy. Among these complications are:

1. Malignancy of the tumor or possible malignant change during pregnancy.
2. The ever-present danger of torsion of the pedicle of the cyst, as exemplified in this case report, with gangrene of the cyst.
3. Suppuration of the tumor.
4. Hemorrhage into the cyst.
5. Rupture of the dermoids with an associated chemical peritonitis.
6. Mechanical interference with labor by the cyst obstructing the presenting part.
7. Malpresentation and uterine inertia.

Any, or all, of the various complications may occur during gestation. If the cysts are discovered during the first trimester, and no acute surgical condition demands an immediate operation, surgery may be delayed, as the optimum time for operation in such cases is at about the fourth month of gestation. At this time, the placenta has taken over the production of estrogen and progesterin, and the corpus luteum can be removed without endangering the continuance of the pregnancy on this basis. Removal of the corpus luteum of pregnancy before the placenta has formed will most likely result in abortion. Also, at this stage of the pregnancy, the uterus is not too large and need be handled very little, and the danger of abortion is thus reduced to a minimum. However, in the event of an acute emergency, such as torsion of the pedicle, immediate operation should be done regardless of the period of pregnancy. If this occurs during the early weeks of pregnancy and the tumor contains the corpus luteum, adequate amounts of progesterin should be given daily.

During the last trimester, watchful waiting is recommended until the fetus is close to term, then Cesarean section and removal of the dermoid cysts is carried out. The possibility of obstruction of labor by the cyst, and the danger of the cyst rupturing from the pressure of the presenting part with possible resulting chemical peritonitis, contraindicates delivery per vaginam. In addition, the sudden release of pressure from the pedicle at the time of delivery may cause a marked dilatation or even rupture of the vessels supplying the cyst, thereby causing an intracystic hemorrhage.

As regards the type of operation, total extirpation of the ovaries together with the dermoid cysts, or resection, is best decided at the time of laparotomy. Ideally, one should attempt to leave as much normal ovarian tissue as possible. Andrews, et al., recommend bilateral salpingectomy if both ovaries have been removed.

The successful conclusion of the pregnancy in this case initiates an interesting endocrinologic discussion. Experimental evidence, as shown by

the literature, supports the belief that the placenta completely assumes the hormonal functions of the ovary. The exact period at which this transfer takes place has not, as yet, been definitely established. It is safe to assume that total transfer of function, with complete safety to the fetus, is assured at least by the ninetieth day following conception. With this in mind, the value of progesterin therapy in this case is problematic. However, used as a complement to the already existing hormones, progesterin probably acted as a sedative to the uterus. It probably also bridges the gap of diminished hormonal production following the trauma of an operative procedure. The synergistic action of estrogen and progesterin, as brought out by Smith and Smith in 1940, would have warranted a trial of therapy. That is to say, the therapeutic action of progesterin would have been enhanced by the simultaneous use of estrogenic hormone.

SUMMARY

1. Another case of bilateral dermoid cysts with bilateral oophorectomy complicating pregnancy has been added to the 57 cases already reported in the literature.
2. The complication of torsion of the pedicle of one of the cysts supports the general agreement that these cysts should be removed during pregnancy.
3. Operation, if possible, should be deferred until after the ninetieth day of gestation.
4. Though the need for progesterin therapy following operation is not imperative, it is a valuable adjunct to postoperative care at any stage of the pregnancy.

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The records in the chest diagnostic clinics prove that the physicians of the state, if they are determined to do so, can perform a better job of suspecting and discovering active tuberculosis cases, year in and year out, than any other agency. It is noteworthy that in the past year, as in other years, more cases of active pulmonary tuberculosis were found among the referrals by physicians to the chest diagnostic clinics than in any other groups of people examined.—Comm. on Tbc., N. H. Med. Soc., New England J. Med., Oct. 23, 1947.

Early Diagnosis of Dacryocystitis and Congenital Glaucoma

CLAUDE S. PERRY, M.D.

THIS article is not intended to present something new or novel. It is intended, rather, to discuss two conditions appearing in infants—dacryocystitis—stoppage in the tear sac or duct, and congenital glaucoma—hardening of the eyeballs.

Usually the mother calls attention to tearing of one of the baby's eyes. The skin may become chapped, reddened, and rough where the tears run over the cheek. The lashes may be matted together, the conjunctiva thickened and red. The area over the lacrimal sac may be swollen. Pressure on the sac will cause the milky yellowish contents to exude through the puncta onto the eyelids.

TREATMENT

There is a rational approach to treatment which is directed to establishing drainage between the tear sac and the nose, plus counteracting the infection. The physician must be sure that the mother who administers the treatment understands what she does. First, she should be shown how to press on the tear sac to express its contents. She must be cautioned of the hazard of long, pointed fingernails. After carefully wiping away the secretions, a couple drops of adrenalin (1:1000, one part in fourteen parts distilled water) should be instilled. Having evacuated the contents of the tear sac, some of this solution will enter the sac. In three or four minutes, the adrenalin solution is repeated. Then, after another three minutes, a few drops of aqueous Merthiolate 1:3000, or a 15 per cent sodium sulfacetamide solution is instilled. This is done while the baby is having his formula or bottle and should be repeated two or three times daily.

We do not use ointments because the oily base would only clog up the drainage system further. We do not use argyrol or similar chemicals which would form a coagulum—silver proteanate—and further plug the canaliculi.

It is most important to advise the mother in advance that it may require several months of treatment. Probing of the sac and duct in the presence of infection, must be done carefully, with the baby under anesthesia. We prefer that the patient have a course of treatment before probing is contemplated as most cases will respond nicely to treatment making probing unnecessary.

CONGENITAL GLAUCOMA

Congenital glaucoma, sometimes called "buphthalmos" or "ox eye", represents a late stage

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when the eyeball is enlarged. The term "infantile glaucoma" would seem appropriate because it implies that symptoms might occur anytime during infancy. Suspicion is first aroused when someone remarks about the baby's beautiful eyes—meaning large eyes. It may be that some increase of pressure resulting in stretching and enlargement of the eyeballs will occur before the congestive symptoms appear. These congestive symptoms are usually the early symptoms of infantile glaucoma and may be listed as follows: (1) Photophobia in which the sensitivity to light may be extreme; (2) tearing; (3) forceful and tight closure of the lids; (4) cloudiness of the cornea which may start in the center of the cornea and extend outward; (5) redness or hyperemia of white of the eye—bulbar conjunctivitis; and (6) is a bilateral condition. The first four symptoms may confuse the physician at first to believe he is dealing with a keratitis.

In the early congestive stage there is usually little enlargement of the globe, so that the condition might be confused with conjunctivitis or keratitis. The resulting delay in arriving at a correct diagnosis may result in enlargement of the eyeball and partial or total blindness.

The tension or hardness as measured with a tonometer is often 50 to 60 mm. of mercury (Schiotz). The treatment is surgical and should be accomplished without delay. In recent years, the operation known as goniotomy, perfected by Doctor Otto Barkan, appears to be more successful than any type of surgery previously tried. Medical treatment will not arrest the disease. In 1946, of the 3,689 children in schools for the blind in the United States, 302, or 8.2 per cent, were there because of congenital glaucoma. During the same year in the Ohio School for the Blind, 18 of the 203 in the school suffered from this disease.

Submitted March 12, 1948.

The Effect of Streptomycin on Eighth Nerve Function

WILLIAM F. HULSE, M. D.

THE phenomenon of antagonism of one organism to another has only been recognized by the medical profession as a whole for a rather short period of time. To those whose special interests lie in the general field of bacteriology antibiotics has been well known for about seventy years. It was at one time felt that more than one type of organism sharing the same culture medium would eventually present the stronger as physically crowding out the weaker; this primitive postulation reposed for many years on the threshold leading to what may well turn out to be the greatest therapeutic armament of all time. It was not until 1939 that astute biological investigation brought forth the tremendous implication that here was a method which could within a few years give hope of treatment to many an enigmatic disease before which the medical profession has hitherto stood helpless.

Prior to investigative work on the antibiotics it appeared that certain of the sulfonamide derivatives would eventually be of great enough benefit that most of the more difficult infections would succumb to these preparations; they may well turn out to be. At the present time, however, the hope of any therapeutic value to any great degree in certain instances is indeed dim but certainly not extinguished. The sharp edges of the drug combined with the uncertainty of results in chronic infections preclude for the moment their widespread use. Certainly the sulfonamide derivatives present in their present state of development far fewer toxic manifestations than in their pioneer state. Yet, the sound tenet justly prevails that these preparations should be attendant with cautious administration because of their noxious side reactions. The discovery of streptomycin by Waksman held forth a promise from its inception that here for the first time was a preparation which could attack and kill many organisms which other preparations were helpless to effect. It is generally agreed that this, and other antibiotics, in some mysterious manner, so disturb the metabolism of the organisms that they succumb to metabolic indigestion. This lethal catastrophe is in marked contrast to the effect of the heavy-metal bacteriocidal preparations.

Most discoveries in the field of therapeutic medicine follow a well-defined pattern, and streptomycin is no exception, of rapid enthusiasm leading to a zenith of over-emphasis. The clinical investigation which has and is being carried

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out by competent investigators everywhere has delineated to a marked degree the limitations of this preparation and statistical material is gradually producing a sound foundation for future evaluation. It appears certain, however, that streptomycin is likely to survive the wild enthusiasm of lay writers who in the past have picked the fruits of medical research while still green. Most of the work on this preparation was done by the V. A. on tuberculosis and this still holds true. One need only go back several months to realize that the reports on streptomycin at that time are now of historical value only. The expansive research and current progress on the subject of streptomycin give evidence that this preparation is still in the early stages of development. Divergent reports on its use bear testimony to this fact also.

There are two factors in the consideration of activity in streptomycin. The first is the effect of this preparation on the body itself and the second is the effect on the selected organism; the two actions have no relationship whatsoever. The first factor may be considered in the light of toxicity to the body and the second in toxicity to the organism. Streptomycin may in a sense be undesirable generally or locally. It has been proven numerous times, both on laboratory animals and humans, to cause degenerative changes in the liver and kidneys, for instance. These changes have fortunately been reversible in practically all cases when administration has been stopped. Gastro-intestinal irritation has not infrequently been noted as have certain skin changes; these have been less frequent however since the product has been produced in a crystalline form but they are still factors to be kept in mind.

The two components of the eighth nerve probably were the first to be noted as presenting unde-

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sirable side reactions. They are unpredictable and may not even occur at all but when they do they may be quite disturbing, both to the physician as well as the patient, since at the present time we know so little about this important problem.

During early administration larger doses than are now thought reasonable were given. For some reason or another, it was felt that three grams of this substance need be given over a period which might last for several months. It was soon evident that certain ill effects were taking place in vestibular function. These effects occurred in the form of what is mistakenly termed as vertigo. This observation was false in that true vertigo does not take place. Rather, it is a feeling of dizziness or dyskinesia. The cerebrum is willing but the locomotion is weak and the patients stagger about and in the advanced manifestations of this symptom must rely on some support. This dizziness is also felt in the reclining position and patients have stated that they must at times brace their head against the bedboard to be comfortable. Under the protocol of three grams, this has in some instances been of a rather permanent nature; or at least it has persisted up to the present time. Since the sense of balance has an ocular as well as a proprioceptive component, these patients are able to compensate rather well except in the dark. They do not respond to caloric stimulation and their labyrinths are considered to be non-functioning. There are, of course, various degrees of dysfunction and it would seem that as long as they have a little function remaining, they get along better than one would reasonably expect.

DEAD LABRYNTH RARE

Of about 150 patients who have been followed and surveyed regularly, I have found only one and possibly two patients with what I considered to be a dead labrynth; these patients had two grams over a period of one to several months. These patients incidently are now showing a slight return of function after they have been off streptomycin for about six months. We have in the past several months used from time to time a dosage of one-half gram daily; under this regime, we have noted only a very few who experienced dizziness and those were so slight that they could not be evaluated with any degree of accuracy.

If patients are to present symptoms of labrynthian dysfunction, they will usually do so in about three weeks. The appearance of vestibular symptoms may not even occur until later but if they do, they are not so marked. Under dosages of two grams or below, these symptoms have all been reversible although the disappearance may take several months.

The cochlear component of the eighth nerve

may present certain findings under streptomycin also although the appearance of symptoms are not so noticeable to the patient. The symptoms of cochlear and vestibular disturbances are in no way related. A patient who is receiving streptomycin has in the past received this preparation for what was and is a serious infection. They are, therefore, subjected to the toxic effects of their disease. One would expect the audiogram to show a certain loss of higher tone acuity prior to streptomycin administration and this is just what we find. In the current doses of streptomycin, we therefore find that the hearing in general improves somewhat at the onset. If the patients, however, are sensitive to streptomycin the hearing will subsequently sag. The acuity loss occurs mostly beyond the conversational range and therefore the patient is not particularly aware of it's occurrence. In my experience, this higher register loss has been reversible and the patient who is fortunate enough to respond to treatment will eventually possess better bearing than he did while under the toxic influence of his original disease.

STREPTOMYCIN ACTS WHERE?

It has been and still is a moot question as to just where streptomycin acts on the eighth nerve system. The eighth nerve is, of course, composed of two components which are in most respects unrelated and therefore one would not reasonably expect them to react to extracurricular influences in the same manner even though their receptive end-organs are so intimate. Considerable research has been carried on in an attempt to designate the seat of the toxic activity of streptomycin. Up to the present time, this problem remains unsolved even though laboratory animals overwhelmed with streptomycin have up to the present time donated no contribution.

It is, of course, most desirable to determine whether or not a given organism is sensitive to streptomycin. In the field of otolaryngology, we are always confronted with a mixed infection, providing there is ulceration. Because of this fact, therefore, we are justified in using this preparation with the certainty that some of the invaders will be affected. It must be kept in mind, however, that the primary organism may become resistant after a period of streptomycin administration. In tuberculosis, this resistance does not occur until about forty-five days in the average case but when it does, it appears to be permanent. For acute cases, therefore, it would seem to be ideal.

Our experience in the immediate past has been with the protocol of one half-gram daily dosage and this seems to be about as adequate as the more generous amounts. Under this regime, we have found that whatever results ensue are comparable to those in the higher brackets.

Rupture of Solitary Cyst of the Liver

C. R. LULENSKI, M.D.

CYSTS of the liver are infrequent, and rupture of a solitary nonparasitic liver cyst is one of the most rare of surgical emergencies. Hepatic cysts have been the subject of many reports¹ through ¹⁷ and this patient is being added in view of several points of interest and particularly because an acute abdomen was present.

CASE REPORT

A. G.—No. 8032—Admitted to St. Alexis Hospital on August 27, 1947. This 42-year-old obese, white female gave history of irregular recurrent high midepigastric pains for the past three years. These were accompanied by constipation and a dislike for fatty foods. Two cholecystograms and one gastro-intestinal series during this time revealed no pathology. There was slight relief by diet and medication.

One month before entrance she had an episode of severe high right epigastric pain with reference to the right infrascapular region. This was attended by diaphoresis, weakness, and nausea. There was infracostal pain on deep inspiration with radiation to the left shoulder for a few hours. After bed rest for three days she felt better.

About ten hours prior to admission, severe generalized abdominal pains ensued and were associated with nausea, vomiting, and prostration. In a few hours the pain localized to the low abdomen.

Examination: Temperature, 100; pulse, 104; respiration, 24; blood pressure, 110/80; hemoglobin, 12.6; white blood count, 11,500. All pertinent findings were in the abdomen. There was tenderness throughout the low abdomen, most marked in the right lower quadrant. Pelvic and rectal examinations were negative except for pain on manipulation of the pelvic organs. Diagnosis was peritonitis due to perforation of the appendix or a peptic ulcer.

OPERATION

Right lateral rectus incision was made. There were about 100 cc. of thin grey-green fluid in the peritoneal cavity with erythema and edema of the serosal surfaces. Appendectomy was performed and incision was extended superiorly. The main pathology was a 4x4x6 inch thick walled, grey cyst on the posterior inferior aspect of the medial part of the left lobe of the liver. At the inferior anterior edge of this cyst there was a one-eighth inch diameter perforation partially closed by grey, mucinous semisolid material. Posterior to this, the cyst was adherent to the superior edge of the pylorus. The cyst was aspirated and dark green fluid, having the appearance of stagnant bile, was obtained. A large section of the cyst wall was removed. The partially denuded surface on the superior edge of the pyloric-duodenal junction was peritonealized by a silk pursestring. The gallbladder, common bile duct, duodenum and the remainder of the liver and the stomach were normal. The

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kidneys were normal to palpation. The abdomen was closed in layers. Culture of the fluid showed no growth.

PATHOLOGIC SECTION

The cyst wall submitted measured one-eighth inch in thickness. Microscopic section revealed inner lining of a single layer of cuboidal to columnar epithelium with basally situated, uniform round blue nuclei and pink-staining granular cytoplasm. Outside this layer is a rim of tissue composed of polyhedral to elongated cells with uniform round blue nuclei and pink-staining vacuolated cytoplasm. These cells are in direct apposition to each other and resemble hepatic cells. There is connective tissue to each side of this rim and at one region there are small spaces lined by a single layer of cuboidal to columnar epithelium resembling biliary ducts. The outer aspect of the cyst wall has a single layer of mesothelium (peritoneum). Diagnosis: Nonparasitic biliary cyst. The patient made an uneventful convalescence.

Gastro-intestinal series, six weeks postoperatively showed no pathology. At the present, six months after the operation, this patient is on a full diet and the only complaints are mild constipation and a dislike for fatty foods.

DISCUSSION

Few symptoms are caused by liver cysts and when they do occur they are due to pressure on the adjacent organs causing swelling, pain, dyspepsia, nausea, vomiting, loss of weight, change in bowel habit and jaundice. Intestinal obstruction may be caused. Perhaps more definite symptoms arise from the complications such as infection, hemorrhage into the cyst, torsion or strangulation of the pedicle and rupture. At times there is increased discomfort on standing with some lessening of pain on lying down. Because of the lack of characteristic symptoms, most of the cases are operated for other pathology or on a preoperative diagnosis of other disease. Liver cyst should be considered in the differential diagnosis of obscure right upper quadrant pathology.

The patients are usually between forty and sixty years of age and females predominate

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four to one. Any cystic mass at the upper abdomen should have gastro-intestinal roentgenological study to differentiate among ovarian cyst, pancreatic cyst, mesenteric cyst, and hepatic cyst. Liver cysts are easily movable from side to side, but are stable in the anterior-posterior direction and tend to displace the transverse colon inferiorly. Various percussion notes have been described and diagnostic pneumo-peritoneum has been suggested, but neither is of much actual value.

At operation the surgeon must distinguish between the thick, laminated-walled hydatid cyst, spillage of which is a catastrophe, and the retention cysts with the smooth thin wall. The internal tension within a nonparasitic liver cyst is low compared with hydatid cysts.¹⁵ For this reason it is rare for a retention cyst to rupture.

In the event that polycystic liver disease is found and the kidneys show similar pathology, no surgical intervention is indicated. If a solitary, nonparasitic cyst is the pathology and is recognized as such, total excision, marsupialization or packing with gauze should be done. If marsupialization is performed, irrigation with a sclerosing agent is in order at intervals until there is closure of the cyst. Should packing be done, re-packing at intervals with irritant impregnated gauze is necessary until closure is accomplished. Anastomosis of the cyst to the intestine has been advised, but does not seem to be a practicable procedure. If the cyst is large, gradual decompression should be instituted with epinephrine or pituitary extract available to prevent shock.

Postoperatively fever may occur and when high and prolonged it is probably due to the absorption of toxic products from the traumatized cyst bed in the liver. The average operative mortality is about 22 per cent,⁵ but with the present preoperative and postoperative measures it should become less.

Classification is somewhat indefinite due to the small number of certain of the liver cysts. The most complete lists have been advanced by Ackman and Rhea,¹ Jones,¹² and McCaughan and Rassieur.¹⁴

Hepatic cysts may be subdivided into nine classes: (1) Degenerative (with polycystic kidneys). (2) Teratomata or dermoids. (3) Lymphatic. (4) Endothelial. (5) Hemangiomas. (6) Cystadenomata. (7) Ciliated epithelial. (8) Pseudocysts or traumatic bile cysts. (9) Retention or nonparasitic biliary cysts of which the case presented is an example.

The right lobe of the liver is most often involved because it contains the greater part of the parenchymatous tissue. That these are rare is shown by Eliason and Smith,⁷ who reported that of 211,046 hospital admissions, only in two was a solitary nonparasitic cyst found at

operation, and in a series of 20,000 autopsies, there were 88 cases of nonparasitic cysts of the liver and 39 of these were of the solitary type. Thus far, about 250 cases of solitary nonparasitic cysts of the liver have been reported as surgically treated and only one had ruptured (Davis⁵), and this had occurred about three days prior to operation.

Author's Note: The author wishes to express his appreciation to Dr. A. Skur for referring this patient.

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Eclampsia

Eclampsia is not a new disease, for convulsive attacks during pregnancy have been described by ancient writers; but it does seem to be a disease endemic to woman, since there is no similar disease reported in animals.

The incidence of eclampsia varies in different localities and in different countries. It is more common in cold than in tropical countries; yet the incidence in the southern part of the United States is about the same as that in the northern states. Various observers have felt that seasons or the weather influence the frequency of occurrence. Davis and Harrar noted a greater number in the New York Lying-In Hospital in April; Zinsser found more in the spring or autumn associated with sudden changes in the weather or a drop in temperature.—R. E. Jones, M.D., Tifton, Ga. *Jrnl. of Medical Association of Georgia*, Vol. XXXVII, No. 6, June, 1948.

Psychiatric Units in General Hospitals

JOHN D. O'BRIEN, M. D.

IN 1929 we opened a Psychiatric Unit in Mercy Hospital, Canton, Ohio. It has been in operation continuously since that date. With modern equipment and facilities for eleven patients, we have felt quite proud of it, and also of our achievements in this small unit.

The personnel consists of a charge nurse, who should have psychiatric training; she has an assistant and two members of the Training School Senior Class, who can acquire their psychiatric nursing experience in their own hospital; there is in addition a nurses' aide comprising the personnel in charge. An important function of the psychiatric service is the training of special personnel. Nurses have a much closer contact with patients than in any other branch of medicine, in their case study, careful observation notes, and therapeutically in their attitude towards behavior; in the end a more thorough understanding of psychiatry.

Each patient entering the hospital is placed abed, and all the facilities of the staff are available and utilized. Treatment for a physical disorder is guided by a specialist in any pathological condition exposed. An efficient laboratory is available where any and all biochemical investigations can be carried on, under the department of medicine, and in a modernly equipped and standardized hospital. In the meantime needed information concerning the patient in question is obtained from the family physician, relatives, and friends; interviews obtained and with all data available, the psychiatrist can plan his therapy.

This ward is licensed by the Department of Public Welfare, has a psychiatrist in charge, while an interne on service in general medicine is available and on call for any emergency. Recently we have added another psychiatrist.

Since 45 per cent or more of the admissions to a General Hospital are psychotic, it is imperative that in the plans of any new hospital construction provisions should be made for a Psychiatric Ward. In such a ward provisions should be made to accommodate 15 patients in a 300-bed hospital. Rees and Billings concluded that in the State of Colorado alone, from 3,000 to 9,000 psychiatric patients are annually admitted to general hospitals. Most of these patients are admitted with physical diagnoses and are not known to be psychiatric patients at the time of admission.¹

Many patients with obvious mental illness are

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dumped on the threshold of the General Hospital, through the emergency room. Scarcely a day goes by that there is not brought to the emergency room some one who has attempted suicide by swallowing poison or disfiguration in another style.

Early diagnosis and treatment is admittedly essential in many somatic diseases, and is equally true in psychoses.

Postoperative, postpartum cases, reactive depressions, personality maladjustments, psychoneurotics, manic depressive group, schizophrenia, involutional melancholia, paretics, these and consultations throughout the hospital provide the type mental disorders met. If these are seen early, screened thoroughly, and treated properly, they respond to treatment within a short time. (The cost and time consumed in treatment is no more than the cost of care of a fractured leg.)

The hospital management states maintenance of a psychiatric unit in a General Hospital is a decided asset and profitable—it meets the Community needs, it is indispensable for nurses' training, its value and service to the Community cannot be measured in dollars and cents.

Referral of cases is most generally from the family physician, who is able at all times to call and see the patient and advise the psychiatrist concerning anything of interest in the family group. This intimate contact with the family physician convinces him that the patient does improve, recover, and is returned to his home. The effect on the community is wholesome, friends of the patient comment on the success of such an undertaking and assume a more wholesome attitude toward the hospital and psychiatry in general.

The psychiatric ward in the General Hospital gives the general practitioner an opportunity to gain an insight into the physician-patient relationship, in their ability to view the patient as a whole rather than a carrier of an isolated diseased organ or system, and also a better com-

¹Read before the Cleveland Society of Neurology and Psychiatry Meeting on October 22, 1947, in Canton, Ohio.

prehension of a tried systematic method of dealing with functional disease.

Another important asset in the treatment of psychiatric cases in the General Hospital is that the psychiatrist profits by contact with other specialists to the patient's advantage—good for each other and the practice of medicine.

The average stay of our patients in the hospital varies from three to eight weeks, our turnover being rapid. If further hospitalization is necessary, we advise the family accordingly.

I feel newer forms of therapy during the past five or six years have augmented very much the duration of the illness in many of these cases. We aim to dismiss our patients early, and have them return twice weekly for continuation of their treatment, if it is electric shock therapy, always accompanied by their family or friends.

My own experience has spanned both preshock and postshock eras, and I feel that the quality of remissions seen in dementia praecox in combined insulin and electric shock therapy, is of a much higher standard than in those cases not treated in that manner. This impression I reached by interviews and follow-up letters to the families, interviews with the physicians and patients during the past seven years. These reports are very gratifying.

During the past five years we have had under treatment hospitalized 580 patients with frank acute psychoses, most all of whom are females. Our greatest increase of patients has been in the past two years, when we averaged more than 700 patients. Ambulatory treatments have averaged eight to ten patients daily.

SUMMARY

There has been given a description of a psychiatric unit in operation in a General Hospital for the past 17 years, which answers the question fairly well of how to handle psychiatric cases in a General Hospital, with ease, profit to the hospital, and very little objection, if any, or annoyance to any part of the hospital.

Since more than 45 per cent of admissions to a General Hospital have psychiatric implications, I feel it is imperative to provide a space for treatment where they can receive efficient diagnosis, benefit of an up-to-date staff, modern laboratory facilities, and intensive therapy. The cost of such treatment is comparable to any ordinary illness of that duration.

Psychiatric ward in a General Hospital is a gap between home and a State Institution—a better opportunity is had for dealing with personality, social problems, and human relations, and is likewise devoid of legalistic routine. Witness the success attained in the Receiving Hospital, where 80 per cent of the patients are voluntary admissions.

The trend to treat patients in General Hos-

pitals has greatly increased since the introduction of shock therapy. This is a good sign, a healthy one. It will lighten the burden on State Institutions. It leads to a better understanding of the psychosis among the general practitioners and hospital staff. It creates a better feeling. It tends to make the public accept psychotic patients as ill individuals, for whom there is some hope of recovery and return to an acceptable community life.

The public is hospital conscious at present, and are demanding such care in a General Hospital.

The presence of a psychiatric unit in a General Hospital will make adequate early treatment available to great numbers of patients who would otherwise not receive it.

The educational and mental hygiene opportunities in a community possessing a psychiatric division in a General Hospital are obvious, and over a period of years may well prove effective in determining a more healthy mode of life for many individuals, who will never be seen as patients.

The nurse with psychiatric training, I find, is a much improved nurse.

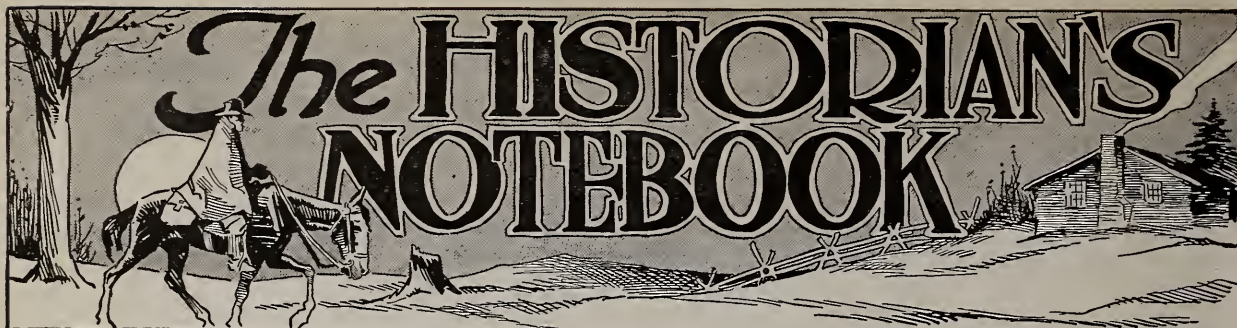
The treatment of mental disorders in a General Hospital is not new, the question in my mind is why was it ever discontinued?

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Ocular Emergencies

Foreign material in the eyes is probably the most common complaint of those seeking medical advice because of an acute eye condition. Small foreign bodies frequently lodge somewhere in the conjunctival sac or in the cornea. When this occurs the predominant symptom is pain or a scratchy sensation in the eye, the severity of the symptoms depending upon the location of the foreign body. In searching for such foreign bodies a good light is essential and the simplest is that produced by an ordinary condensing lens which will focus the light from an incandescent lamp on the eye. If the foreign body is found either on the upper or lower palpebral conjunctiva, or on the bulbar conjunctiva, it can usually be removed very easily with a toothpick swap. In the case of conjunctival foreign bodies generally no anesthetic is necessary. However, if the object has become embedded in the cornea a local anesthetic is necessary before removal is attempted.—William P. McGuire, M.D., Winchester, Virginia. Virginia Medical Monthly, Volume 75, Number 7, July, 1948.



Ohio Medicine in 1876

JONATHAN FORMAN, M.D.

IN working over the files of the *Ohio Medical Recorder* and the *Columbus Medical Journal*, the thought has occurred to us that the editorials of the two consecutive Ohio publications ought to bring to the attention of our readers some interesting notes.

The *Ohio Medical Recorder* began its first volume with the June issue, 1876. Dr. John W. Hamilton, father of the late Charles and Will, and Dr. James Fairchild Baldwin were the editors.

Its first editorial naturally was a "Salutatory." In giving the reason for its existence, the editors noted that the local societies throughout the State were gathering with great zeal and industry the fruits of professional experience and observation. These papers were of great value but there was no repository for them.

"Outside of Cincinnati, Ohio has not a single medical journal representing the interests of the regular profession. . . .

"We offer the *Ohio Medical Recorder* to the medical men and medical organizations of the State as a central means of communication and as a repository of their productions."

Throughout this editorial one can sense the arrogance with which the *Ohio Medical and Surgical Journal*, owned privately by the professors of The Starling Medical College, had been ignored by those who had broken away to form their own medical college and medical journal. But this could not be for long. In the second issue, we find the editors answering a circular which had been issued by Dr. Starling Loving and his faculty, owners of the *Ohio Medical and Surgical Journal*, proving that the *Ohio Medical and Surgical Journal* was owned at the time of its suspension by the faculty of the Starling Medical College.

"We should have taken notice of the reply but for the fact that its olla-podrida of verbiage tended to confuse and mislead the reader as to the real point at issue."

In this issue, too, the editors are elated over the A.M.A. meeting in Philadelphia attended by over 750 in all, thus setting a record. At the meeting of the Ohio Medical Society at Put-In-Bay, the attendance was smaller than the previous year, there being less than 100 present.

In going through the editorial pages for things of interest, it should be apparent that we can only supply a set of notes lacking in continuity.

Editorial recognition is given to another member of the faculty of The Columbus Medical College—Dr. H. Culbertson of Zanesville, professor of ophthalmology, who had been awarded by the American Medical Association a valuable prize for an essay on "Exsection of the Four Principal Joints."

The editors were worried about the disgrace to the profession when directly contradictory testimony is presented to the court by medical experts, and urged, as many do today, that such matters be attended by a committee of physicians appointed by the court. [It has always seemed to me that such a procedure would deprive the jury of valuable information on controversial points upon which, in some instances, the very outcome of the case depends. Since medicine is not a science and never will be, medical opinion can never be as clean-cut as is demanded when a commission is to tell the court whether the accused was sane or insane at the time he committed the crime.—Editor.]

In the September issue, comments were made upon the organizational meeting of the Convention of the American Medical Colleges, which has grown since then into a powerful organization. At that time, however, our editors summed up the first meeting as follows:

"All things considered, we cannot feel that much has been accomplished by this movement. What the ultimate result may be, we will not undertake to predict; but to us, a survey of the possibilities in the case is far more agreeable than that of the probabilities."

Social Insurance . . .

Germany's Years of Experience With Problems Similar to Those Involved in Social Security Measures in the U.S. Are Reviewed

THE German sickness insurance act, introduced in 1883, was the first of the compulsory social insurance programs. Autonomous local Funds, which collected premiums and distributed benefits, were organized along occupational lines. Premiums were set at 1½ per cent of wages, two-thirds to be paid by the insured and one-third by the employer. Statutory benefits consisted of free medical care for thirteen weeks and a cash benefit amounting to 50 per cent of the local wage rate, paid from the fourth day of illness. In 1903 benefits were extended to twenty-six weeks and a system was instituted whereby each local Fund could vote to increase premiums and supply additional benefits, such as greater cash allowances, shortened or no waiting period, nursing and convalescent care, and coverage for the contributor's family.

In 1914, 170 out of 10,000 Funds collected premiums amounting to more than 4½ per cent of wages; by 1925, four-fifths of the Funds collected over 6 per cent. Coverage was also extended to include domestic and agricultural workers and all manual laborers with incomes of less than 3600 marks. When the program reached its peak in 1928, over 91 per cent of contributors' families, and three-fifths of the entire population, were insured. During the period of expansion, the main changes were: An increase in the provision of medical care benefits over cash benefits; emphasis on preventive rather than compensatory health insurance; and the extension of benefits to families of contributors. This overoptimistic expansion led to the breakdown of the system in the depression. As unemployment increased, contributions decreased. The government was unable to assist the health program because of a decline in tax revenues and the need to subsidize unemployment insurance. Benefits were curtailed and it was not until Hitler came to power that his artificial stimulation of the German economy put the program on its feet again.

COST OF ADMINISTRATION

The cost of administering the German health insurance program is estimated at 9.6 per cent of total expenditure for the program in 1914, and 6.8 per cent in 1925. This decrease in cost is due more to the soaring in expenditure than to greater administrative efficiency. If the legal and postal services performed free of charge by the government, and the bookkeeping costs of employers are calculated, the expenses are

The accompanying article is a summary, without critical comment, of "German Experience with Social Insurance," by Walter Sulzbach, Ph.D., formerly professor of economics and sociology, University of Frankfurt. It is edited from a release of the Bureau of Medical Economic Research of the American Medical Association. To summarize: Social Security measures in the United States have not yet been tested under adverse economic conditions; Germany has operated state-sponsored welfare programs for over half a century. Dr. Sulzbach reviews the history of German social insurance in order that America may foresee the economic and psychological problems which she will face in the future and prepare against them.

considerably higher. Perhaps a more accurate picture is given by the fact that four Fund workers were employed for every three insurance doctors.

MALINGERING

During the period of German health insurance, the duration of illness increased progressively from 14.1 days per illness in 1885 to 29.3 days per illness in 1932. The latter figure is 70 per cent higher than in the United States. Cash benefits, which were often almost equal to full wages, made it possible for the worker to take a paid vacation on sick leave at the Fund's expense. Supervising doctors, appointed to curb such abuses, found up to 50 per cent of the persons on sick lists able to work. A similar situation exists under England's compulsory health insurance program.

During the depression, an emergency measure required the payment of a small fee for medical services and prescriptions; insurance claims promptly dropped more than 50 per cent in many companies. The principle of risk-sharing, used by private insurance companies, has been recognized by other health insurance countries; in France and Denmark, 15 to 25 per cent of the costs of medical care are paid by the insured. The Wagner-Murray bill of 1945 empowers the Surgeon General to take like measures when necessary to prevent abuses. Risk-sharing seems to be the only effective way to check malingering.

THE MEDICAL PROFESSION

At the outset in Germany health insurance was not socialized medicine, and was not opposed

by the medical profession. The conflict between physicians and the program was over matters of technique rather than basic philosophy. **As long as the upper two-thirds of the income groups were not covered, the program benefited the profession.** Private practices were not seriously affected, and young or only moderately successful physicians took advantage of the opportunity to treat patients who otherwise could not afford medical care.

From 1883 to 1913, the Funds hired voluntary physicians. The insured had no choice of doctors, physicians were underpaid, and a great deal of graft was apparent in the system. In 1913, the medical profession organized, threatening to withdraw medical services from the Funds. Medical faculties of the German universities mediated, and an agreement was reached. Contract committees for the profession and the Funds were formed; each Fund contracted for the services of several doctors; workers were free to choose any of the physicians on the Fund roster. Payment was on a capitation basis; a lump sum was distributed to the Fund doctors according to number of patients treated and work done.

By 1928, 80 per cent of German doctors were employed either full or part time by the Funds, and their pay, averaging \$2,620 annually, constituted 60 per cent of all medical earnings. The Funds maintained one physician per 1,350 insured persons, and one physician per 1,000 insured persons with insured dependents. The ratio was reduced to one physician per 600 insured during the depression in order to aid doctors who had lost their private practices.

As physicians received standard fees for their services, **their incomes depended on the number of insured patients treated, rather than on the quality of the service.** If a doctor liberally certified that workers were entitled to benefits, he was popular and his income was greater than that of a physician who attempted to thwart malingerers. The workers complained that physicians gave them insufficient care and preferred their private patients. If beneficiaries expect the personal care which they receive under private practice, and if physicians are to be paid according to their merits, health insurance premiums would have to be raised to a level that would exclude the lower income groups.

The achievements of the German health insurance program are difficult to estimate. Infant mortality and the death rate showed a substantial decline after compulsory health insurance went into effect, **but no more so in health insurance countries than in countries without such programs.** The deficiencies of the system are far more apparent, and are instructive to American social planners. Supervising doctors had to be withdrawn from practice in order to pre-

vent abuses. Malingering made premiums excessively stiff and reduced production by increasing unnecessary absenteeism. Risk-sharing was absolutely necessary, but extremely unpopular. The incidence of the premium paid by the employer fell on the worker in the form of lower wages or decreased employment; **thus the entire cost of the program was actually borne by the insured.**

ACCIDENT INSURANCE

Accident insurance is more widespread than any other form of social insurance. Germany set the pace in 1884 with a system in which occupational associations paid the entire contribution for manual laborers in their fields. Premiums were determined by the size of payrolls and the risks involved in each occupation. This system proved unfair, as preventive measures by an employer might cut down accidents in his plant, while his premium was determined by the risks of the entire occupation. Benefits included medical treatment for thirteen weeks, later extended to twenty-six weeks; funeral benefits and survivors' pensions in case of death; and a pension amounting to two-thirds of basic wage rates for total incapacity, with proportionately lesser amounts for partial incapacity. By 1928, 66 occupational groups were covered, and benefits had been extended to cover occupational diseases and accidents occurring on the way to and from work. **During the depression, the burden upon employers proved too heavy, making it necessary to restrict benefits and to reduce contributions by one-third.** The accident insurance program was continued and strengthened under Hitler, who found, as had Bismarck half a century before, that the German people would willingly exchange their liberty for apparent security.

INVALIDITY AND OLD-AGE

The first invalidity and old-age insurance measures were passed in Germany in 1889, covering civil service servants and disabled veterans. By 1916, all occupational categories included under the health insurance program were covered, with benefits paid to workers over 65 years of age and to invalids unable to earn one-third of the wage of persons of like education and training.

UNEMPLOYMENT INSURANCE

Unemployment insurance was instituted in Germany in 1927, covering all manual, domestic, and agricultural workers in low income groups. Benefits were paid for twenty-six weeks of unemployment, after which the worker was eligible for emergency benefits up to thirty-two weeks. The program was administered by an autonomous body with local, district, and national offices, which collected contributions and distributed benefits. Assuming that unemployment

would range from 1 per cent to 5 per cent of the working population, the administration set rates at 3½ per cent, with employees and employers contributing equally. Soon after the plan was put into operation, the depression caused a sharp curtailment of benefits. Premiums were increased, compensation was reduced from twenty-six to twenty weeks, the rights of children and married women who had paid premiums were repealed. Thereafter the program was supported by government subsidies and became a system of relief rather than insurance.

CONCLUSION

Two trends are apparent in the history of German social insurance: the general expansion of expenditures, benefits, and coverage; and the increasing use of government subsidies to supplement employer and employee contributions. In 1885, 4.7 million Germans were insured; expenditure for social insurance amounted to 52.2 million marks. By 1931, 23.3 million persons were covered, and expenditures had risen to 5,571.7 million marks. While private contributions rose 217 per cent from 1913 to 1930, Federal contributions went up 746 per cent, totaling 475.7 million marks in the latter year. In 1929, health insurance took care of an average of 855,000 sick persons per day; two million persons were receiving old-age and invalidity benefits; and 1,275,000 received unemployment benefits. One German in six—11,189,000 persons—drew part or all of his income from social insurance.

The reasons for this expansion of German social insurance lie more in its value to politicians and bureaucrats than in its accomplishments. Costs of administration were high, ranging from 6 to 13 per cent of expenditure for the different programs, in addition to legal and postal services and employers' bookkeeping expenses. The programs restricted the freedom of the worker to spend his money as he pleased. Assessments upon the employer were actually shifted to the worker, who was no better off than under private insurance.

Obstetrics and Gynecology

The annual meeting of the American Board of Obstetrics and Gynecology, Inc., was held in Washington, D. C., May 16-22, at which time 231 candidates were certified. A number of changes in board requirements and regulations were made. New bulletins are now available for distribution upon application. The next scheduled examination (Part I), will be held in various cities of the United States and Canada on February 4, 1949. Applications may be made until November 1, to the office at 1015 Highland Bldg., Pittsburgh 6, Pa.

Orthopedic Society Elects

Officers elected for next year by the Ohio State Orthopedic Society at its annual meeting May 14-15 at Columbus were the following: Dr. Joseph Freiberg, Cincinnati, president-elect, and Dr. J. I. Kendrick, Cleveland, secretary and treasurer. Dr. E. H. Wilson, president, presided at the meeting.

Next year's meeting will be held during May in Cleveland, at which time Dr. Rudolph Reich, Cleveland, who assumed office at the conclusion of the 1948 meeting, will preside.

Highlight of the meeting was an address by Dr. George Deaver of New York City on rehabilitation. Included on the program were the following: "Infantile Cortical Hyperostosis" by Dr. Warren Wheeler; "Anterior Bone Block of the Knee," Dr. Henry Lacey; "Case Reports of Unusual Cases," Dr. E. H. Wilson; "Colona Operation of Dislocated Hips in Children," Dr. Judson Wilson; "Physical Therapy for Traumatic Injuries," Dr. Shelby Gamble.

"An Evaluation of Various Types of Bone Grafts," Dr. B. R. Wiltberger; "Spinal Fusion," Dr. Clyde Dawson; "Skin Grafting in Massive Scarring of the Hands," Dr. A. R. Smith; and "Fibrous Dysplasia of Single Bones," Dr. Hans Schulumberger.

Accidents Cost 120 Million

The total estimated cost of traffic accidents in Ohio during 1947 amounted to \$120,000,000, according to the Ohio Department of Highways. This total includes the estimated property damage (\$49,300,000), wage loss or the value of services due to temporary inability to work, lower wages when returning to work due to permanent partial disability, etc., (\$46,000,000) medical expense, including hospital fees (\$2,700,000), and insurance costs which include all administrative, selling and claim settlement expenses, but not the money paid (\$22,000,000). The above figures are based on 1,600 fatal accidents, 44,000 personal injury accidents and 290,000 property damage accidents.

Ohioans Receive Research Grants

Three Ohioans will benefit from an additional \$103,000 in research funds for heart disease announced recently by the Life Insurance Medical Research Fund in New York. Largest grant in aid announced by the fund, is \$18,375 for research by Dr. Normand L. Hoerr of Western Reserve University, on the capillary circulation of intra-abdominal organs. Student research fellowships go to Lewis T. Franklin, Chillicothe, to work under the supervision of Dr. Harold D. Green at the Bowman Gray School of Medicine of Wake Forest College, and to Robert E. Neuman, Cincinnati, to work under the supervision of Dr. Milan A. Logan at the University of Cincinnati College of Medicine.

Medical Licensure . . .

State Boards Issue 14,429 Certificates To Practice in 1947 With Net Gain Throughout the Country of 3,280 Physicians

OHIO was among the six leading states in number of licenses to practice medicine issued during 1947. This is shown in the Forty-Sixth Annual Presentation of Licensure Statistics by the Council on Medical Education and Hospitals of the American Medical Association as reported in the June 12 issue of *The Journal of the American Medical Association*.

During 1947 there were 14,429 licenses to practice medicine issued by the medical examining boards of the 48 states, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands. Of these licenses, 6,747 were issued after examination and 7,682 by reciprocity and endorsement of other state licenses or of the certificate of the National Board of Medical Examiners.

IN OHIO

In Ohio 634 licenses were issued, 327 by examination and 307 by endorsement. Examinations were given to 300 applicants, 297 of whom passed. Applicants for examination in Ohio were from medical schools of the following educational institutions: University of Southern California 1, Loyola University 7, Northwestern University 7, University of Chicago 2, University of Michigan 1, St. Louis University 1, University of Nebraska 1, Cornell University 1, University of Rochester 2, Ohio State University 74, University of Cincinnati 81, Western Reserve University 75, Hahnemann Medical College and Hospital of Philadelphia 13, Jefferson Medical College of Philadelphia 1, Temple University 2, University of Pittsburgh 1, Woman's Medical College 1, University of Tennessee 1, Southwestern Medical College of the Southwestern Medical Foundation 1, University of Manitoba 1, foreign medical faculties 7, extinct medical schools 1, unapproved medical schools 4, and schools of osteopathy 14. Of the three applicants who failed, one was from a foreign faculty and two from schools of osteopathy.

Of the 14,429 licenses to practice medicine and surgery issued, the greatest number (1,868) were issued in California. New York issued 1,645 and Illinois 904. Pennsylvania and Texas, in addition to Ohio, issued licenses to more than 600. The fewest number of licenses were issued in Nevada with 19.

While in 1947 the number licensed was greater than in any prewar year, there were 1,802 fewer licensed than in 1946. The decrease in licenses issued was evident only in the group licensed

without examination. Those registered after examination numbered 185 more than in 1946. In the 13-year period from 1935, 130,052 medical licenses have been issued, 82,049 after examination and 48,003 by endorsement of credentials. The number licensed after examination was the largest number in any one year with the exception of 1944 when the number was 7,062.

OHIO MEDICAL COLLEGES

Graduates of Ohio's three medical colleges took examinations in 14 states as follows:

Ohio State University College of Medicine—California 3, Florida 4, New York 3, Ohio 74, Pennsylvania 3, West Virginia 2, Territories 1; total 90; number passed 87. .

University of Cincinnati College of Medicine—Alabama 1, California 2, Florida 6, Idaho 1, New York 7, North Dakota 1, Ohio 81, Pennsylvania 2, West Virginia 3; total 104; passed 101.

Western Reserve University School of Medicine—Florida 5, Massachusetts 1, Minnesota 1, Mississippi 1, New York 7, Ohio 75, Pennsylvania 2, Territories 2; total 94; passed 91.

Certificates of the National Board of Medical Examiners are recognized by the medical licensing boards of 45 states, including Ohio, and the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Canal Zone. In 1947, 2,312 diplomas were granted licenses to practice medicine on the basis of their National Board Certificates in 42 states and in the territories. In 1947, 1,743 tests were given in part III of the examination; 1,725 passed and 18 failed.

From March 1, 1947, to March 1, 1948, 3,002 were certified by 16 specialty examining boards.

Official figures indicate that last year 6,855 individuals were added to the physician population in this country and the territories. The number removed by death in the United States, its possessions, and those who were temporarily located in foreign countries in the same period was 3,575. It would appear that the physician population was increased by 3,280 new licentiates in 1947.

Dr. Stanley A. Dorst, Dean of the University of Cincinnati College of Medicine, recently received the honorary degree of doctor of science from his alma mater, Wittenberg College, Springfield.

Laws Enacted by Congress . . .

Digest of More Important Medical-Health Proposals Which Were Passed Before Adjournment and List of Measures Which Failed

A review of the record of the 80th United States Congress reveals that it enacted an unprecedented number of important measures dealing with health and medical subjects.

Congress adjourned late in June. However, during the Democratic convention, President Truman called it back into special session which opened on July 26. What will happen on proposals which had been shelved at the regular session is problematical.

Following is a digest of measures enacted during the regular session and reference to some proposals which died in committee or on the calendars.

Stream Pollution: A measure known as Public Law 845, which sets up a nationwide stream pollution program, was one of the most important enactments. What it means so far as Ohio and the Ohio River Valley is concerned is described in a special article, appearing elsewhere in this issue.

World Health: Public Law 643 will enable the United States to become a member of the World Health Organization which is now in session at Geneva. Among the official representatives is Dr. James R. Miller, a member of the Board of Trustees of the American Medical Association.

Heart Disease: Known as the National Heart Act, Public Law 655 provides for Federal grants for research, fellowships, control programs, etc. A token initial appropriation of \$500,000 was voted. It establishes a National Heart Council. A National Heart Institute will be set up in the new clinical research center of the U. S. Public Health Center, Bethesda, Md. The heart program will be patterned after the existing Federal cancer, venereal disease, and mental disease programs.

Hospital Expansion: The Hill-Burton Hospital Survey and Construction Act was liberalized in several ways. Public Law 713 makes the Virgin Islands eligible to participate in Federal grants. Public Law 723 will give states which have not enacted enabling legislation more time to do so. Public Law 830 fixes a minimum grant to any state at \$100,000. This will help a few states whose population-per capital income formula was so low that grants were under the \$100,000 mark.

Dental Research: Public Law 755 sets up a National Institute on Dental Research; provides for an advisory council; appropriates funds

for a building at Bethesda; and authorizes \$750,000 annually for grants in aid for dental research. The bill was authored and steered by Congressman Walter E. Brehm, Ohio, a dentist. In an appropriations act, the U. S. Public Health Service was granted \$1,000,000 for demonstrations of application of sodium fluoride to children's teeth.

Health Service Officers: Promotion and retirement benefits comparable to those accorded

Selective Service Law

Before the National Selective Service Bill was passed by both houses of Congress (Public Law 759), an amendment was adopted eliminating the provision which would have permitted the calling up of physicians up to 45 years of age as a special group. As the law now stands, only physicians within the age group, 19 to 25, inclusive, and who are eligible to be drafted will be selected under the Selective Service Law for active duty. Physicians with more than 90 days of wartime service between Pearl Harbor and V-J Day, or with at least one year of service since September, 1940, exclusive of time spent in specialized training programs, will not be subject to the draft under the present law.

Army and Navy commissioned officers, were granted Public Health Service officers in Public Law 425, sponsored by Senator Taft, Ohio.

Veterans Administration: Public Law 729 provides for research and development program in prosthetic and sensory appliances at an expenditure of \$1,000,000 annually. The results are to be made available to private agencies and individuals. Public Law 722 permits the V. A. to establish intern training programs in V. A. hospitals. Public Law 702 authorizes Federal aid up to \$10,000 to enable service-connected paraplegia cases to acquire or remodel dwellings so as to be suitable for them. Public Law 748 adds certain tropical and chronic diseases to the list of conditions which are presumed to be service-connected if shown to exist within one year after separation from active duty.

Food and Drugs: Amending the present statutes, Public Law 749 makes it a criminal

offense to adulterate or misbrand drugs, food, therapeutic devices, and cosmetics even after interstate shipment has been completed and they are ready for retail sale, whether or not the first sale.

Army-Navy: Public Law 716 gives the Navy parity with the Army in procuring and appointing medical service corps officers, including pharmacists, optometrists, psychologists, etc. The Army Service Corps was created by Public Law 337. Public Law 36 strengthened the Army and Navy Nurse Corps. Public Law 365 added a flat \$100 pay boost to Army, Navy, and Public Health service physicians and dentists.

Reorganization: Authored by Congressman Clarence Brown, Ohio, Public Law 162 establishes a commission to reorganize the executive branches of the Federal Government. That commission, headed by Ex-President Herbert Hoover, is at work. It will report next March to the new Congress.

Not Enacted: Among measures, some of which are extremely controversial and which were not enacted and probably will come before the Congress again in some form or another, were the following:

S. 1320, the Wagner-Murray-Dingell compulsory health insurance measure; S. 545, the Taft National Health Program measure; S. 140, the Fulbright-Taft bill to create a Federal Department of Health, Education, and Security; S. 2385 to establish a National Science Foundation, which was vetoed by President Truman H. R. 5644 to expand and strengthen Federal aid to states for local public health departments; H. R. 6732 to create a polio research institute; and S. 1290, the so-called school health bill.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since June 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

BELMONT COUNTY

Charles L. Liggett,
St. Clairsville

Mary L. Scholl, Columbus

Robert R. Sommer,
Grove City

BUTLER COUNTY

Edward Kezur, Hamilton

HANCOCK COUNTY

Herbert L. Selo, Findlay

CUYAHOGA COUNTY

Paul Chrenka, Cleveland
Jay W. Cohn, Cleveland
F. R. Hanrahan, Cleveland
Robert E. Holmberg, Cleveland
F. J. Hruby, Cleveland
Bradley Hull, Cleveland
Richard B. Schenk, Cleveland

JACKSON COUNTY

Elizabeth C. Innis, Jackson

LUCAS COUNTY

Donald A. Koch, Toledo

PORTAGE COUNTY

Robert M. Dumm, Kent

STARK COUNTY

Delmar R. Gard, Alliance
Ray R. Mosley, Alliance

FRANKLIN COUNTY

Francis C. Boyer, Columbus
Edwin H. Ellison, Columbus
Edgar R. Miller, Columbus
Paul Q. Peterson, Columbus

SUMMIT COUNTY

Robert B. Hosier, Akron
George H. Mansfield,
Cuyahoga Falls
Richard T. Yoshikawa,
Akron

Progress Report on the Ohio Academy of General Practice

Officers and committees of the Ohio Academy of General Practice are grinding away at the task of organization and six additional local units have been organized, all of which are in localities comprising large numbers of the general practice group, according to a report submitted to *The Journal* by Dr. Joseph Lindner, Cincinnati, president of the academy.

Dr. Lindner also submitted the following report regarding the recent meeting of the American Academy of General Practice in Chicago.

The annual meeting of the Congress of Delegates of the American Academy of General Practice was held at the Sheraton Hotel, Chicago, on June 21. Ohio was represented by two delegates, Dr. James Lemmon, Akron, and Dr. Joseph Lindner, Cincinnati. Twenty-three other states were also represented.

An extremely well organized business meeting considered a number of topics. A revised constitution and by-laws was widely discussed and adopted. Usage proved the original document to be inadequate in some respects, thus making revisions necessary.

A number of committee reports were presented. Outstanding was the report of the Hospital Committee. American Academy of General Practice members and hospitals at large can rest assured that much thought and study is being given to the all important problem of establishing the best possible relations between the general practice group and the hospitals.

The Committee on Education also gave a comprehensive report on plans for improving the training programs both in medical schools and hospitals so that the quality of general practice will be improved and maintained on a high level. Numerous resolutions were presented and acted upon.

The long and intense business session was terminated with a re-election of the present officers to serve for an additional year and the designation of Cincinnati, Ohio, as the place for the first National Convention of the American Academy of General Practice. The meeting will be in late March, 1949.

A banquet that would rival the efforts of any of the long established medical groups was held at the Sheraton Hotel on the evening of June 21. The occasion was one wrought with enthusiasm. No one could feel other than that the accomplishments of the American Academy of General Practice for its first year were exceptional and that much good is in store in the future for the members of the organization.

Governor Herbert has appointed Dr. Claude S. Perry, Columbus, a member of the Ohio Commission for the Blind, for a term ending July 7, 1953.

A. M. A. Annual Session . . .

Hundreds of Ohio Doctors With Their Families Converge on Chicago For One of the Largest Meetings of the American Medical Association

MORE than 700 Ohio physicians joined other Fellows of the American Medical Association for the 97th Annual Session in Chicago, June 21-25, and witnessed what was declared the most extensive A.M.A. session with the exception of last year's Centennial meeting in Atlantic City.

Many of the doctors made the occasion a household outing and took members of their families on the trip to Chicago. The total registration was 11,963 Fellows. Doctors' wives, guests, exhibitors, and members of their families swelled the attendance to nearly 22,000.

OFFICIAL REPRESENTATION

Representing the Ohio State Medical Association as Delegates to the American Medical Association were the following: Drs. Edgar P. McNamee, Cleveland; Carl A. Lincke, Carrollton; George A. Woodhouse, Pleasant Hill; William M. Skipp, Youngstown; Frank M. Wiseley, Findlay; L. Howard Schriver, Cincinnati; and C. C. Sherburne, Columbus.

Three Ohio delegates were appointed by the Speaker to reference committees. Dr. Carl A. Lincke was appointed to the Committee on Credentials, Dr. L. Howard Schriver to the Committee on Medical Service and Prepayment Insurance, and Dr. George A. Woodhouse to the Committee on Emergency Medical Service.

Ohio doctors who attended as officials of the American Medical Association included: Dr. E. J. McCormick, Toledo, member of the Board of Trustees; Dr. Russell L. Haden, Cleveland, member of the Council on Medical Education and Hospitals; Dr. Torald Sollmann, Cleveland, chairman of the Council on Pharmacy and Chemistry; and Dr. Richard L. Meiling, Columbus, of the Committee on National Emergency Medical Service.

Dr. Paul A. Davis, Akron, member of The Council, Ohio State Medical Association, and president of the American Academy of General Practice, was elected by the A.M.A. Section on General Practice as a delegate from that section to the House of Delegates of the A.M.A. for the ensuing year.

OHIOANS TAKE PART

Ohio physicians who presented medical papers or scientific exhibits included the following:

From Cleveland—Drs. Russell L. Haden, Donald W. Bortz, Irvine H. Page, George Crile, Jr., Robert L. Faulkner, John A. Toomey, H. T. Karsner, Clyde L. Cummer, W. James Gardner,

Guy H. Williams, Theodore A. Willis, U. V. Portmann, R. J. Whitacre, William L. Proudfit, A. Carlton Ernstene, Howard Dittrick, Carroll Glenn Barber, Samuel L. Robbins, Walter M. Solomon, Walter J. Zeiter, William S. Dempsey, Lorand V. Johnson, E. C. Weiford, O. P. Kimball, Harry R. Trattner, Maurice D. Sachs, Harold R. Rossmiller, Wilbert McGaw, Harold E. Snedden, and J. Muckley.

Actions of House of Delegates To Appear in September Issue

A report of actions taken by the House of Delegates on resolutions, as well as other highlights of the A.M.A. Annual Session in Chicago, will be given in the September issue of *The Journal*.

From Cincinnati—Drs. B. Noland Carter, Max M. Zininger, William A. Altemeier, Nina A. Anderson, A. R. Vonderahe, Leon Schiff, S. A. Safdi, R. C. Cogswell, C. W. Kumpe, D. F. Richfield, E. A. Gall, Nicholas J. Giannestras, Theodore H. Vinke, Edgar White, and Benjamin Felson.

Others from Ohio included, Drs. Robert M. Zollinger, Jonathan Forman, editor of *The Ohio State Medical Journal*, and John H. Mitchell, of Columbus; Dr. W. R. Hubler of Youngstown; Drs. Rex H. Wilson, Paul A. Davis, Glenn V. Hough, and William E. McCormick, of Akron; Drs. Herbert L. Brumbaugh and John J. Shea, of Dayton; Dr. Dudley M. Stewart, of Toledo; and Dr. James R. Tillotson, Lima. Dr. Henry J. John, Cleveland, Dr. Thomas P. Sharkey, Dayton, and Dr. Cecil Striker, Cincinnati, were on a program of clinics and conferences on Diabetes. Representing the executive staff of the Ohio State Medical Association's Headquarters Office in Columbus were Charles S. Nelson, Executive Secretary, George H. Saville, Hart F. Page, and Gordon Moore.

NATIONAL OFFICERS

The incoming president of the Association is Dr. R. L. Sensenich of South Bend, Ind. Dr. Ernest Edward Irons, Chicago, was chosen the new president-elect. He will take office at the Atlantic City session in 1949.

Other officers or Council members elected by the House of Delegates are: Dr. Roy W. Fouts, Omaha, vice-president; Dr. George F. Lull, Chi-

cago, re-elected secretary; Dr. Josiah J. Moore, Chicago, treasurer; Dr. Francis F. Borsell, Philadelphia, speaker; Dr. James R. Reuling, Bay-side, N.Y., vice-speaker; Dr. Alphonse McMahon, St. Louis, member Council on Scientific Assembly; Dr. Harvey B. Stone, Baltimore, and Dr. William L. Pressley, Due West, S.C., members of Council on Medical Education and Hospitals; Dr. Henry B. Mulholland, Charlottesville, Va., and Dr. Joseph D. McCarthy, Omaha, members of Council on Medical Services; Dr. John H. O'Shea, Spokane, Wash., member of the Judicial Council.

The following were elected to the Board of Trustees; Dr. Gunnar Gundersen, La Crosse, Wis. (1953); Dr. Edward S. Hamilton, Kankakee, Ill. (1953); and Dr. Walter B. Martin, Norfolk, Va. (1951).

FATHER, SON WIN GOLF EVENTS

Dr. Allen N. Wiseley, Jr., Euclid, Ohio, won the 1948 championship of the American Medical Golfing Association at Olympia Fields. He was presented with the famous Will Walter Trophy on a score of 154 (76-78) for 36 holes.

The Maturity event for A.M.G.A. members 60 years and older went to Dr. A. N. Wisley, Sr., Lima, Ohio, whose name will be engraved on the Minnesota Trophy.

Dr. George Wilcoxon, Alliance, Ohio, was top man in the Obstetrics-Gynecology group of golfers. Bob Elwell, executive secretary of the Toledo Academy of Medicine, was chosen again as assistant secretary-treasurer of the organization.

ART

A number of Ohio physicians whose artistic abilities have been directed toward the field of art as a hobby were represented with contributions to the American Physicians' Art Association. Award of the "Popularity Trophy" will be announced later. Nearly a thousand works of art were on exhibit.

OPERATIONS BY TELEVISION

Television demonstrations which foreshadow new techniques in postgraduate and perhaps basic medical education were highlights of the session. The program was planned by Northwestern University School of Medicine in cooperation with the American Medical Association, the Radio Corporation of America, Passavant Hospital, and E. R. Squibb and Sons. Under the setup, 1,500 medical observers could witness a single demonstration. This estimate included 500 at the Navy Pier, 600 in the Sherman Hotel, and 400 in classrooms at Northwestern University.

Dr. Isaac Abt of Chicago was selected by the House of Delegates to receive the Distinguished Service Award of the American Medical Association.

Two Physicians Leave Ohio for Medical Faculties in West

Ohio this summer is losing two physicians well known in the field of medical education to medical faculties in other states.

Dr. George T. Harding, III, clinical professor of neurology and psychiatry at Ohio State University College of Medicine, and medical director of the Harding Sanitarium at Worthington, accepted the presidency of the College of Medical Evangelists in Los Angeles, Calif.

He succeeds Dr. Walter E. McPherson as head of the Seventh Day Adventist institution. Dr. Harding had been on the Ohio State University medical faculty since 1930, and was actively engaged in the practice of medicine in Columbus.

He is a past-president of the Columbus Academy of Medicine, and was a member of the Franklin County Tuberculosis Sanitarium and the Metropolitan Health Council. He is a former member of The Council, Ohio State Medical Association, and is now chairman of the Committee on Mental Hygiene. It was announced that he will retain his position as president of the board of directors of the sanitarium.

Dr. William B. Bean, associate professor in the field of medical research at the University of Cincinnati College of Medicine, has accepted the position as professor of medicine and head of the department of internal medicine at the State University of Iowa College of Medicine.

Dr. Bean has been identified with medical research at the University of Cincinnati for more than a decade. During the war, while with the Army Medical Corps, he directed several medical research projects.



G. T. HARDING, M.D.



W. B. BEAN, M.D.

The Chicago Ophthalmological Society will hold its second annual clinical conference Nov. 29-Dec. 4. Further information may be had by writing Miss Maud Fairbairn, 8 W. Oak St., Chicago 10.

Better Health for Millions . . .

Assured by Signing of Ohio River Valley Water Sanitation Compact at Cincinnati and U. S. Act Authorizing Anti-Stream Pollution Program

WEDNESDAY, June 30, 1948, was a red letter day in the history of efforts which have been put forth over a period of years to curb the pollution of the Ohio River and its tributaries and thereby establish additional necessary health protection for millions of residents of Ohio and other states in the Ohio River Valley.

On that date the official signing of the Ohio River Valley Water Sanitation Compact took place in Cincinnati.

Because this project is of vital public health significance, the Ohio State Medical Association has actively used its influence to secure the proper legislation in the Congress and in the legislative bodies of all states concerned, authorizing the compact. An active role also has been played by the Cincinnati Academy of Medicine in promoting the program which is one of the most important public health projects ever undertaken in Ohio.

FEDERAL AID VOTED

Dovetailing with the signing of the compact was the signing by President Truman on June 30 of a Federal act appropriating funds for an active program of water pollution control by the U. S. Public Health Service which will be of great benefit to the Ohio River Valley.

This article reviewing the history and need for the compact and the Federal legislation and outlining the activities which will be undertaken and the benefits which will accrue is based on information obtained by *The Journal* from Mr. F. H. Waring, chief engineer, Ohio Department of Health, and secretary of the Ohio River Valley Water Sanitation Compact Commission.

EIGHT STATES IN COMPACT

The eight states included in the compact are: Illinois, Indiana, Kentucky, New York, Ohio, Pennsylvania, Virginia, West Virginia. Signators for each state included the Governor, the Secretary of State, and three duly appointed commissioners; also three persons representing the Federal government. Seven of the eight states designated the state health director as an

ex officio member of the commission to represent that state; likewise, one of the three Federal commissioners was the Surgeon General of the U. S. Public Health Service. The public health significance of the compact has therefore been given official recognition.

REASONS FOR AGREEMENT

One of the principal causes for an agreement to curb the pollution of the Ohio River developed many years ago when drouth conditions accentuated tastes and odors from industrial wastes imparted to public water supplies taken from Ohio River. All effort to remove these objectionable tastes and odors by modern water purification methods have failed. The people forced to drink Ohio River water after purification had been driven by these objectionable tastes to other sources of drinking water, many of which were questionable.

Another cause for an agreement to curb pollution was the toxic effects noted for the first time during the drouth periods of 1930 and 1934 and reported upon by the U. S. Public Health Service, whereby the products of decomposition of sewage and organic solids in the river water were said to have resulted in sickness of those using the river water, even after the best known methods of water purification had been practiced. A warning was sounded by health authorities that ill effects noted in extreme drouth periods would become of regular occurrence in dry weather periods of ordinary years if steps were not taken to curb the inflow of pollution materials.

It has not been generally understood by the public at large that raw untreated sewage from nearly 5,800,000 persons in municipalities on the Ohio River watershed and treated sewage from an additional population of more than 2,400,000 persons was discharged into the main river and its tributaries; that over 6,200,000 persons were supplied with water taken from the river and its tributaries, of which 1,500,000 were supplied with water from the Ohio River itself. Not a single municipality along the main river afforded any treatment of sewage, with the

Mark Your Calendar

For an Early Date To Check the Who, What, and Why of Candidates for the State Legislature, Congress, and Other Elective Offices. Who Are Your Candidates in Respect to Background? What Are Their Views on Medical and Health Matters? Why Is One Candidate Better Qualified Than Another?

exception of two small suburbs, one at Ashland, Kentucky, and one at Portsmouth, Ohio, totaling less than 10,000 persons.

INTERSTATE AGREEMENT NECESSARY

The Ohio River is entirely within the borders of three states—Pennsylvania, West Virginia, and Kentucky—although it is bordered upon by Ohio, Indiana, and Illinois. Jurisdictional reasons, therefore, made it necessary for an interstate agreement for the uniform approach to curbing sewage and industrial wastes pollution.

The compact sets forth in easily understood language that all sewage and industrial wastes entering the Ohio River, either directly or by way of its tributaries, must in the future be treated to a degree sufficient to preserve the waters of the streams for legitimate purposes, such as domestic water supply, industrial water, and recreational uses. Minimum degrees of treatment are specified, although judgment is reserved to the commission to determine greater degrees of treatment if the commission is of the opinion that such greater degrees of treatment are needed.

OHIO'S SHARE OF COSTS

Costs of administering the efforts of the commission in bringing about the sewage and industrial wastes treatment requirements will be borne by the states on a basis proportionate to the average of population and area of each state within the Ohio River basin. It is expected that Ohio's share of the commission's expense will amount to 22.6 per cent of the total, the most for any of the eight states involved. On the basis of an estimated annual budget of \$100,000, this would mean an expenditure by Ohio of \$22,600 per annum. It is possible that a greater budget than \$100,000 per annum will some day be needed, although it is estimated that at the beginning this amount should suffice.

In addition to making arrangements for financial contribution, Ohio also will be called upon to enact into statute the requirement that all sewage and all industrial wastes be treated before discharge into any of the state's waters and to such degree as may be designated by the Ohio Department of Health, which has legal jurisdiction over the stream pollution control within Ohio. Such a requirement will make an extra demand upon the Ohio Department of Health for the services of its division of sanitary engineering to review plans for treatment and disposal facilities and to decide upon degrees of treatment needed. Funds for additional engineers to make the stream pollution control recommendations will need to be provided.

PROVISIONS OF FEDERAL ACT

The new Federal enactment signed by President Truman on the same day of the signing of the Ohio River Valley Water Sanitation Com-

pact is entitled, "To provide for water pollution control activities in the Public Health Service * * *." The measure had the joint support of Senators Taft of Ohio and Barkley of Kentucky in the Senate, and Representatives Ellston of Ohio and Spence of Kentucky in the House. In the preamble of the Federal enactment it states, "* * * It is hereby declared to be the policy of Congress to recognize, preserve, and protect the primary responsibilities and rights of the States in controlling water pollution, to support and aid technical research to devise and perfect methods of treatment of industrial wastes which are not susceptible to known effective methods of treatment, and to provide Federal technical services to State and interstate agencies and to industries, and financial aid to State and interstate agencies and to municipalities, in the formulation and execution of their stream pollution abatement programs. * * *"

OHIO WILL BENEFIT

There is included in the Federal enactment authorization for an appropriation of a total of \$4,000,000 for the construction and equipping of facilities at Cincinnati for study of the pollution of interstate waters and the training of personnel in work related to the pollution control of interstate waters. Likewise, there is authorized to be appropriated a sum not to exceed \$2,000,000 to enable the U. S. Public Health Service to staff and operate these stream pollution and control facilities. An appropriation of \$1,000,000 per year for five years is authorized to be allotted to state and interstate agencies for expenditure by them, and to supplement their own appropriations, in their water pollution control activities.

One more financial provision of the enactment makes it possible to extend aid to municipalities by way of nominal grants to pay for the planning of sewage treatment works. The grant thus indicated shall not exceed one-third of the cost of the planning nor shall it exceed \$20,000 per project, whichever is the smaller.

Supplementing the financial aid provisions of the Federal enactment are enforcement provisions that can only be called into play at the request of the state or interstate agency having jurisdiction over stream pollution control wherein the alleged stream pollution offense occurs.

Throughout the compact and legislation concerted action by interstate agreement and Federal enactment has been brought about insofar as statutory provisions are possible. It now remains for the proper agency in each state and the interstate agency to undertake the actual task of bringing about the construction and operation of the necessary stream pollution control works involving the treatment of sewage and industrial wastes.

Division of Vital Statistics . . .

23,000 Birth and Death Certificates Signed by Ohio Doctors Roll Into Columbus Office Each Month for Permanent Filing

OHIO physicians each month sign approximately 17,000 birth certificates and 6,000 death certificates. These original records are destined for the Ohio Department of Health where they are processed and filed for future reference. The procedure of keeping this endless accumulation of records so that any designated one will be available upon request is the principal (but not the only) duty of the Division of Vital Statistics.

Activities of the Division date to 1908, when the Bureau of Vital Statistics was established in the office of the Secretary of State. Prior to that year, records were kept by respective probate courts, with no central depository. Legislation enacted during that year provided for local registrars throughout the state. In 1921 the administrative code transferred the bureau to the Department of Health and designated it as the Division of Vital Statistics. Today the Division, housed on the ground floor of the State Office Building, employs a personnel staff of approximately 50, and is represented by 1,050 local registrars throughout the state. Chief of the Division is Mr. William Veigel.

PROGRESSIVE STEPS OF REGISTRATION

Local registrars make a copy of every birth and death certificate for local files, and forward originals to district health commissioners. Health commissioners of county and city districts in turn forward original records to the Division of Vital Statistics. This procedure is a monthly routine. Registrars are required to forward certificates by the fifth of each month following month of filing. Commissioners, after making suitable records for their files, forward them to the Columbus office by the tenth of the month.

The attending physician by law is required to file a certificate of birth with the local registrar within 10 days after delivery. Funeral directors are responsible for filing certificates of death, but in each case the attending physician must complete and sign the medical section. Health authorities point out that records of deaths are more nearly complete than records of births. Perhaps one reason for this is that the remains of a body may not be buried or otherwise disposed of without a burial permit, which cannot be secured until a certificate of death is filed. The stork, on the other hand, is oblivious to certificates.

Stillbirth registration is considered by Division personnel to be well below the number that should be expected. Perhaps this is partially due to a misunderstanding of what constitutes a still-

This is another in a series of articles on the organization, functions, and programs of the Ohio Department of Health and its subdivisions, under Dr. John D. Porterfield, director.

birth. The Ohio law defines a stillbirth as "an infant of at least four and one-half months of uterogestation whose sex can be determined, which after complete expulsion does not give evidence of heart action, breathing, or movement of voluntary muscles."

COPIES IN DEMAND

Certified copies of birth certificates are very much in demand, especially since the war. During the past five years, the Division supplied five times as many copies as it did during its entire prewar history. More exacting demands on the part of employers for birth certificates from workers as well as requirements of the Veterans Administration and other agencies have stimulated this increase. Survivors seeking to cash war bonds account for many of the demands on the Division for copies of death certificates.

Anyone whose birth certificate is on record may obtain a certified copy by paying a fee of 50 cents. The usual form issued is a photostatic copy with a certification attached. Two other types may be substituted. One of these types is a pocket-size certificate of birth registration encased in transparent plastic. The other is a certificate of framing size. Neither of these forms shows the names of parents, a condition which makes them ideal in cases of illegitimate births.

A system of multiple checks is used by personnel in the Division, but in spite of all precautions at least 15 per cent of the original certificates contain undetected errors, Mr. Veigel stated. Errors usually indicate haste on the part of parents and others in giving information, or lack of appreciation for the certificate's importance. Only in a few instances are errors apparently caused by neglect on the part of physicians. Errors are much more numerous in certificates from former years than they are in those of current years. The number of birth certificates in proportion to actual births also is approaching the goal of 100 per cent.

ONLY 95.6 PER CENT

A special survey was made at the time of the U.S. Census in 1940 to check the proportion of

births on record. It was revealed that during a three months' test period only 95.6 per cent of births had been placed on record. From these figures Division personnel estimate that there are at least 10,000 Ohioans born each year whose births are not on record. A similar survey will be made again during the 1950 census.

To doubly check the accuracy of certificates received, the Division sends a photostatic copy to each mother after a child is born. This procedure gives parents an opportunity to point out errors. The Division also queries attending physicians in cases of inconsistencies or omissions.

More than the proverbial 99.44 per cent of physicians are cooperative in registering births accurately, Mr. Viegel reported. Only a comparative few are uncooperative or disregard the law. In one county, for example, a preliminary survey revealed that during 1947 as many as 58 births had not been registered.

After certificates are checked for accuracy, they are photographed on microfilm. These microfilm negatives are sent to the Public Health Service in Washington, D.C., where two positive copies are made. One positive is kept on file in Washington. The second and the negative are returned to the Columbus office.

STATISTICAL DATA

A punch card system is used for statistical data. Data on each certificate are coded on an individual card. By running these cards through a tabulating machine, or through a sorting machine, any desired statistical information can be obtained. For example, the machine can be set to sort out cards on all children born with congenital malformations. Or it will sort out cards of persons who died from cancer. The complicated periodical statistical reports on morbidity by counties of the state are made on tabulating machines.

The Division of Vital Statistics carries on liaison activities with other divisions and agencies. For example, it provides the Ohio Department of Welfare with a list of all children born with congenital deformities, the Division of Maternal and Child Hygiene with a list of premature births, the Division of Venereal Disease with venereal disease information, the Division of Tuberculosis with information pertinent to its work, and so forth.

Division personnel provide technical advice to other divisions of the Department concerning planning of specialized programs or collection of special data. They also interpret vital statistics data for Department personnel in planning special health programs.

The Division also has jurisdiction over delayed birth certificates issued through probate courts in the state. For example, persons whose births are not on record may have a certificate issued through the court. Certificates for adopted

children also are issued in this manner. Since April 30, 1941, more than 165,000 delayed certificates have been placed on record.

The intricacies of matching original certificates with new certificates issued upon adoption, or changing the record when the parents of an illegitimate child marry, are only details in the routine of the office.

Physicians Requested To Use Only Permanent Ink on Certificates

Some doctors unknowingly have been completing and signing birth and death certificates with "now-you-see-it-and-now-you-don't" forms of ink. In a number of instances Vital Statistics personnel have discovered recent certificates on which the ink had faded almost completely. Many of the newer colored inks, especially those used in ball point pens, fade rapidly, Mr. Viegel stated. Only inks labelled "permanent," which in most cases are black or blue-black should be used on certificates, he emphasized.

On death certificates some difficulties are encountered in regard to causes of deaths. Medical aspects of causes of deaths and statistical aspects sometimes differ, Mr. Viegel said. As an example, many physicians write "pneumonia" as a cause of death. The Division must know whether it is broncho-pneumonia or lobar pneumonia. In the case of death by cancer, the Division must include the type. Gunshot wounds are recorded specifically as to homicide, suicide, or accidental.

The Physicians' Handbook on Birth and Death Registration is now in process of revision. The revised edition will be ready for distribution late this year. Revised birth and death certificate forms will be available early in 1949.

Mr. Viegel came to the Division in 1936 and was appointed chief in 1941. A native Ohioan, he attended Ohio State University. In addition to his duties as chief of the Division, he is also special agent in Ohio for the U.S. Public Health Service, an office which gives him the privilege of franking notices to parents and inquiries to physicians in matters pertaining to birth and death certificates. He is also a member of the American Registration Executives Association and chairman of the Association's committee on Birth Card Confidential Verification and Fact of Death Report.

Mr. Viegel gives periodic lectures to senior students of medical colleges of the state and has offered his services to address medical societies or other groups interested in the activities of the Division.

Library Loan Services . . .

Facilities Offered by Ohio Medical Libraries and Other Institutions Where Ohio Physicians Can Secure Material for Reference and Research

A QUESTION frequently submitted to the Ohio State Medical Association, especially by members residing in other than some of the metropolitan centers, is:

"Where may I obtain medical textbooks, abstracts, reprints, etc., for research work or for consultation in connection with the handling of difficult or obscure cases?"

This matter was studied by the Committee on Extension of Activities of the Association. The committee decided that it would not be feasible for the Association to establish a packet library. On the other hand, it felt that some plan should be worked out to meet this problem.

A survey was made of present sources of medical literature which are available, or can be made available, to Ohio physicians. The results of this survey are set forth in this article for the information of all members of the Ohio State Medical Association.

A.M.A. LIBRARY

The American Medical Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals published within the past 10 years are available. Requests for issues of earlier date cannot be filled. Requests should be accompanied with stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order.

CLEVELAND MEDICAL LIBRARY

Allen Memorial Library, Cleveland, operated by the Cleveland Medical Library Association, is one of the finest and largest medical libraries in the world.

Members of the Ohio State Medical Association may secure the services of this institution by securing a non-resident membership, costing \$7.50 annually and providing for a free delivery service.

This is one of the best opportunities offered Ohio physicians for library services as the Allen Memorial Library is rated among the leading institutions of its kind.

OHIO STATE UNIVERSITY LIBRARY

Direct extension service to groups and individuals of the Ohio State University Library, Columbus, is limited to circulation of books to

members of the faculty, students in residence, administrative officers and other university personnel, and to members of the Columbus Academy of Medicine. Anyone may have access to library material if he will visit the library.

Nevertheless, the Ohio State University Library maintains the customary inter-library loan program and will lend material which is available to another library to which the original request is made. Not all types of material are available under an inter-library loan. Current numbers of periodicals are not subject to loan except overnight or week ends. Certain books, large, bulky material, rare books and various handbooks used constantly as reference material are not subject to loan. The loan policy varies according to demand on the campus, and the period of loan varies with the type of material requested.

ARMY MEDICAL LIBRARY

The resources of the Army Medical Library, Seventh St. and Independence Ave., S. W., Washington, are available to physicians throughout the United States as a complement to local facilities. Physicians should consult and exhaust first the facilities of local libraries before applying for books and literature from the Army Medical Library.

The following principles govern loans from this institution:

Rare books, works out of print or not easily replaced, loose-leaf material, folios with plates, unbound periodicals, and reference works are not sent out on loan.

Loans are made only to other public or medical libraries or institutions. Individual readers should make their requests thereto.

Material is loaned for two weeks from date of receipt, with the privilege of extension upon request. Transportation charges both ways are to be borne by the borrower. Shipment is made by express collect, unless postage sufficient for mailing is sent with the request.

Every request is required in duplicate, allowing space between items for necessary information. The duplicate will be returned to the institution making the request, with any necessary notations.

The request for a medical book should show: full name of author; title of work, with date and place of publication. The request for an article in a medical journal should show: name of journal; date of issue, or volume number; author's name; title of article, and page on which it appears.

Loans are made on condition that the greatest care be taken in packing the material on return to prevent damage in transit. Among other precautions, the corners and edges of books should be well protected; and pamphlet material should not be rolled, nor placed inside

of books, but sent flat, preferably by mail. The borrower will be expected to repair damages due to poor packing.

For references to medical literature in the Army Medical Library, a physician should consult copies of the Index-Catalogue of the Library of the Surgeon General. Copies of the Index-Catalogue will be found in the following libraries throughout Ohio:

Akron—City Hospital, Library; Alliance—Mt. Union College, Library; Athens—Ohio University, Edwin Watts Chubb Library; Bowling Green—Bowling Green State College, Library; Bucyrus—Bucyrus Public Library; Cincinnati—Cincinnati General Hospital, Library; Cincinnati—Public Library; Cincinnati—University of Cincinnati, Library; Cincinnati—University of Cincinnati, College of Medicine, Dandridge Memorial Library.

Cleveland—Cleveland Medical Library Association; Cleveland—Cleveland Public Library; Cleveland—Lakeside Hospital, Department of Medicine, Library; Cleveland—Lakeside Hospital, Department of Surgery, Library; Cleveland—U. S. Marine Hospital; Cleveland—Western Reserve University, Adelbert College, Library.

Columbus—Ohio State Department of Health, Library; Columbus—Ohio State Library; Columbus—Ohio State University, Library; Columbus—Ohio State University, College of Medicine.

Dayton—Dayton Public Library; Delaware—Ohio Wesleyan University, Charles Slocum Library; Gambier—Kenyon College, Library; Granville—Denison University, Library.

Marietta—Marietta College, Library; Oberlin—Oberlin College, Library; Oxford—Miami University, Library; Springfield—Wardner Public Library; Toledo—Toledo Hospital, Medical Library; Toledo—Toledo Public Library; Van Wert—Brumback Library of Van Wert County.

Many of the foregoing libraries also will have the Current List of Medical Literature, indexing current medical literature, issued by the Army Medical Library. Physicians may subscribe to this if they care to do so at \$3.00 per year through the Superintendent of Documents, Washington, D. C. In addition the Army Medical Library, upon request, will furnish a physician with copies of the Army Medical Library News and Selected List of Recent Acquisitions.

Photoprints or microfilms of material in the Army Medical Library may be obtained from the Library. Cost of photoprints are 50 cents each 10 pages or fraction thereof, from any single volume; microfilms, 50 cents each of 50 pages or fraction thereof, from any single volume. Cash or check, payable to the Treasurer of the United States, must accompany the order.

AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons, 40 East Erie Street, Chicago, offers two types of library

services for all physicians, regardless of fellowships in the College.

The Department of Literary Research of the College of Surgeons' Library compiles bibliographies, prepared abstracts and translations of selected articles, or makes complete reviews of the literature.

In compiling bibliographies the published indices, i.e., the Index of the Surgeon General's Library, Index Medicus, Quarterly Cumulative Index Medicus, and collections of abstracts, such as the International Abstracts of Surgery, are used—supplemented by the checking of current literature in the Library. The number of years to be covered on any subject should be stated when the request is made.

Abstracts are made of the articles selected by the physician from the finished bibliography or a complete review of the literature for a specified number of years is prepared, if that be his desire. The work is done in accordance with the physician's instructions in order that extraneous material may be eliminated from the study and only the information sought by the inquirer be included in the report.

Special care is exercised in the abstracting of articles from the foreign languages to insure accuracy of fact and exact interpretation of meaning. Whenever requested the department will furnish full translations of important articles in order to preserve a complete picture of the material as presented in the original source. The regular staff, equipped to prepare translations from the German, French, Spanish, Portuguese, Italian, Bohemian, Dutch, Polish, Russian, and Scandinavian literature, is assisted by associated part time workers in the Hungarian and other unusual languages.

The Library also maintains a file of 125,000 reprints for loan without charge. Material in point is selected from this classified file and is lent for a period of two weeks (or longer upon request). It is to be returned as soon as it has served its purpose. This is, of course, a limited service as no foreign material is included.

With the exception of the Package Library service, a charge is made for the material furnished by the department. The cost of the bibliographies, abstracts, and translations is based upon the time expended by the research worker in preparing the data. This does not include overhead, cost of supervision or of medical editing. The total cost is kept at a minimum by careful selection of the articles to be abstracted and translated, by the full use of the Package Library Service, and by careful management and organization of the work, using to best advantage the experience of the trained workers on the College staff. The physician requesting the service may indicate a limit of expenditure. In this case, the full amount will not be spent

unless necessary, but the limit will not be exceeded without the physician's knowledge and consent, the most important work being done first.

MISCELLANEOUS SERVICES

Two medical libraries in Cincinnati have lending services which are available to Ohio physicians through an interlibrary loan service, meaning that the physician secures the literature, when available, by making application to his local public or special library. These are: Library of the University of Cincinnati Medical College and Library of the Children's Hospital Research Foundation. It should be remembered that the facilities of these institutions are primarily for members of their staff, so they may not be able to spare data in every instance.

In addition lending services for Cincinnati physicians only are maintained by the Cincinnati General Hospital Library and Christ Hospital Library. These institutions are not equipped to send material out of the city.

Inquiries were addressed to a number of other Ohio medical libraries, asking if they maintained lending services outside of their home cities. However, since replies were not received no information on their facilities and services can be given at this time.

Committee Studies Ohio Public Health System

Study of what changes might be made in Ohio's public health system, both state and local, is now in process by an unofficial committee consisting of representatives of state-wide farm, business, professional and other organizations. Charles S. Nelson, Executive Secretary, representing the Ohio State Medical Association on the committee, was chosen by the group as its chairman.

County Societies Well Represented At 'Grass Roots' Conference

Increasing popularity of the National Conference of County Medical Society Officers was indicated by a well-attended meeting in Chicago on Sunday preceding the Annual Session of the American Medical Association.

This year's meeting was the third annual "grass roots" conference, the purpose of which is "to develop a working partnership between the American Medical Association and every physician."

Ohio was represented by more than 20 officers and executive secretaries of county societies as well as by representatives of the Ohio State Medical Association.

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Enrollment in non-profit prepayment plans for medical care passed the 8,000,000 mark during the second quarter of 1948. The Blue Shield enrollment at the end of the first quarter, covering all non-profit plans in the nation with medical or Blue Cross sponsorship, revealed a first quarter total of 7,928,128 members. Total membership gain during the first quarter of 1948 was 645,222 persons, representing a 9.19 per cent increase over December 31, 1947. Michigan Medical Service continues to be the largest Blue Shield Plan in the United States with a total enrollment of 981,729.

* * *

The much discussed proposal to establish a national service agency for enrolling "national accounts" is still being studied by the Blue Shield and Blue Cross Commissions. When final agreement has been reached by the Blue Shield and Blue Cross Commissions, the completed proposal will be submitted to all Blue Shield and Blue Cross Plans and referred also to the A.M.A. Council on Medical Service, as well as the proper body within the American Hospital Association.

* * *

Another Blue Shield Plan, Iowa Medical Service, has announced the return of capital loans to physicians throughout the state who made financial contributions toward the establishment of the plan. A total of \$21,425 was returned to 857 doctors who had paid \$25 each to become participating physicians when the plan was started. Blue Shield in Iowa now has more than 1,500 participating physicians and more than 50,000 members enrolled.

* * *

Blue Shield Plans will gather at French Lick, Indiana, on October 25-28 for their Third Annual Conference. The Blue Cross Commission also will hold its annual meeting at French Lick Springs in October. Conference programs will be planned jointly by Blue Shield and Blue Cross with separate business sessions scheduled for each organization.

* * *

Mississippi Hospital and Medical Service reports a membership in excess of 16,000 persons since active enrollment was undertaken in January, 1948. It provides both medical and hospital coverage under the joint sponsorship of physicians and hospitals.

Army, Navy Medical Programs . . .

Armed Forces Are Encouraging Doctors To Affiliate by Offering Intern and Residency Training in Service and Civilian Hospitals

THE Army and Navy recently announced expansion of their professional training programs for reserve and regular medical officers, with the twofold purpose of permitting more doctors in service to meet the requirements for certification by the various specialty boards and at the same time to encourage promising young doctors to affiliate with the armed forces.

ARMY

Five major aspects of the training program for Army and Reserve Medical Officers were described by the Surgeon General as follows:

(1) Physicians already resident in civilian hospitals are now eligible for commissions in the Regular Army. Those commissioned may continue their residencies with full pay and allowances from the Army and will be assigned by the Army to the civilian hospital in which they are already resident. Even in the event of an emergency, the chances of these residents to finish their training will be as good as that of civilian residents, according to the announcement.

(2) Civilian interns are now eligible for Army Medical Corps Reserve commissions and may continue their internship with full Army pay and allowances. Those so commissioned will undertake to accept commissions in the Regular Army, and on completion of internship will be permitted to compete for residencies.

(3) During 1948, 500 doctors will be commissioned and assigned to duty at Army hospitals in order to compete for 260 residencies in both Army and civilian hospitals. Competitive examinations will begin either in September or October.

(4) As many as 150 commissions in the grades of major, lieutenant-colonel and colonel will be offered in 1948 and another 150 in 1949. However, applicants for these commissions in higher grades will not be considered for residencies.

(5) Active reserve service for specific positions and limited periods will be offered doctors who are not interested in a regular Army career.

NAVY PROGRAM

The Surgeon General of the Navy has announced a similar program, in which the following are important points:

Graduates of Class A medical schools who have been accepted for internship by a hospital approved for such training by the Council on Medical Education and Hospitals of the A.M.A.

may be commissioned as lieutenants (junior grade), MC, USNR, and permitted to continue their intern training. They will receive all the pay and allowance of the rank while so serving. After completing their internships, the medical officers must remain on active duty for a period of one year. If they meet the professional, physical and moral requirements, they will be given every encouragement to transfer to the regular Navy.

Interns who have completed the one year of obligated service, and who have transferred to the regular Navy, may be considered for residency training on a competitive basis with other officer personnel of the regular Medical Corps.

Resident physicians now in civilian hospitals, or those accepted for approved residency training, are eligible for commissions in the regular Navy. Those so commissioned will be assigned to duty, with full pay and allowances, in the hospital in which they are already a resident, or to which they have been accepted for residency training. Every attempt will be made to permit residents holding commissions in the regular Navy to complete their training in event of an emergency.

The Navy has at the present time 400 approved residencies and fellowships in the various specialties recognized by the American Specialty Boards in Naval and civilian hospitals. This educational training involving the 400 residencies is divided into two programs.

Program A: One hundred of the above-mentioned residencies, courses, and fellowships will be made available for civilian physicians accepting a commission in the U. S. Navy. An additional 100 civilian physicians will be commissioned in the U. S. Navy and permitted to pursue their own course, fellowship or residency, provided it is approved by the Council on Medical Education and Hospitals of the American Medical Association with concurrence of the Specialty Board. Upon acceptance of the designated training, they will be required to agree to remain in the Navy for a certain obligated time.

Program B: Three hundred residencies, fellowships or courses, will be reserved for continuing the Training Program as presently organized for regular medical officers.

The obligated service following graduate medical training (courses, fellowships and residencies) in Naval hospitals is one year for each year of training received.

Rakestraws Find Ohio Too Hot . . .

League For Correction of Cross-Eye Closes Cleveland Office and Apparently Abandons "Clinics" After Legal Action Involves Principals

DUE to a series of events which exposed it as an outfit not in the public interest, and legal actions against several individuals involved, the Mary Rakestraw League for Cross Eye Correction has closed its office in Cleveland which was the base for its questionable activities in Ohio and supposedly has abandoned the holding of so-called "clinics" in various Ohio cities.

Whether the Rakestraw League which has been fooling too many Ohioans for too many years will drop Ohio from its sucker list entirely remains to be seen. Nevertheless, the fact that the league has closed its facilities in Ohio would indicate that the outfit is on the run and may decide that its season of happy hunting in this state is over.

INVESTIGATIONS MADE

Flight of the Rakestraw League from Ohio came as a result of persistent investigations by Dr. H. M. Platter, secretary of the State Medical Board, who was assisted by the office of Attorney General Hugh Jenkins through Assistant Attorney General Joseph F. Ford; articles by Walter Lerch, medical writer, in the *Cleveland Press*, exposing the advertising and activities of the organization; and a series of developments causing discomfort to several who have been playing leading roles in this medicine show which consisted of a one-stop antiquated treatment for cross-eye.

The Mary Rakestraw League was born in Pontiac, Michigan, about 10 years ago. Its purpose doubtless was two fold: To collect shekels from unfortunate gullible persons with crossed eyes and to serve as a capper for an osteopath named L. K. Mathews of Pontiac who was supposed to have something brand new in the line of scientific correction for cross-eye.

INVADE OHIO

It wasn't long until the league was engaged in an extensive newspaper advertising campaign and direct mail solicitation of patients in Michigan cities. After Better Business Bureaus and medical societies in Michigan had challenged the statements made by the league and the methods employed by Mathews, Miss Rakestraw decided to try other hunting grounds.

Several years ago Rakestraw League advertisements began to appear in Ohio newspapers. League literature telling of the wonders of the organization's work was peddled to individuals. Unfortunately, certain civic organizations inter-

ested in those afflicted with eye disorders fell for the outfit's claims and helped publicize its activities.

The advertisements and literature played up "safe, permanent, painless" corrective treatments and talked a lot about the fact that the job was done without "severing of muscles, bandages, or hospitalization" and "during one short office visit." The league announced and held so-called "clinics" where interested persons could go for "interviews." Naturally, the "clinics" did a land office business. So did Mathews, and Mary, and her husband, George. It wasn't long until Ohio physicians began reporting that they had seen patients who had received this wonderful new treatment but who apparently were worse off than before.

USE CLEVELAND M.D.

The Rakestraws opened their Cleveland office about a year and a half ago. Also, about that time they began referring persons to A. W. Laird, M. D., Hippodrome Building, Cleveland. Laird, who has never been a member of the Cleveland Academy of Medicine or the Ohio State Medical Association, holds himself out to be a plastic surgeon. At that time it was rumored that the Rakestraws and Mathews had had a falling out. Since cases are now being referred again to Pontiac, the Rakestraws and Mathews may have patched up their difficulties but the facts are not known.

Spurred on by continuing reports from physicians who had seen some of the results of the operation and by investigations made by agencies who make a business of checking on the truth of advertising statements, the State Medical Board and the office of the Attorney General started to assemble evidence against the Rakestraw League and its principals. They also checked up on Laird.

BREAK COMES

A break came in the investigation late in 1947 when two suits for damages, totalling \$225,000, were filed against Laird by two former patients on whom he had operated for eye disorders. These suits have not come to trial as yet.

Then, early in 1948, George Rakestraw was arrested in Warren on a charge of practicing medicine without a license.

Rakestraw's arrest and suits against Laird, produced a crisis for the league. At conferences, officials of the State Medical Board and office of the Attorney General stated in no uncertain

terms that the Rakestraws and their employees would be arrested each and every time they held interviews in Ohio.

As a result, the Rakestraws apparently decided that Ohio was too hot for them. They pulled up stakes and so far as is known they are no longer holding "clinics" in the state. If they resume, they will be arrested. If they continue to advertise in the newspapers or use the mails for promotional material, a program to expose them will be launched and legal action may be taken.

SEND IN EVIDENCE

If physicians spot Rakestraw League advertising in their local newspapers or hear of any "clinics" being held by the league, they should notify the Columbus office of the Ohio State Medical Association immediately. Ohio has the league on the run and intends to use every possible means to protect Ohio residents from its activities in the future.

Licensed Through Endorsement By State Medical Board

The Ohio State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians through endorsement of their licenses to practice in other states:

April 6, 1948—Vallee W. Blagg, Ironton, Univ. of Louisville; Myrtle V. Collins, Kent, Univ. of Michigan; Louis N. Gould, Oxford, N.Y. Medical College; Thomas F. McGough, New Philadelphia, George Washington Univ.; Dana T. Moore, Columbus, Med. College of Va.; Hugh A. O'Neill, Cleveland, St. Louis Univ.

June 21, 1948—Neil C. Andrews, Columbus, Univ. of Oregon; Howard W. Bangs, Columbus, Syracuse Univ.; John D. Battle, Jr., Cleveland, Univ. of Pennsylvania; George W. Blueglass, Cleveland, Royal College, Edinburgh, Scotland; Charles H. Brown, Cleveland, Rush Medical College; Ray E. Burns, Dayton, St. Louis Univ.; Arthur E. Coyne, Kirkersville, College of Med. Evangelists; William H. Crays, Springfield, Indiana Univ.; Paul G. Cressman, Jr., East Cleveland, Hahnemann Med. College.

Edward B. Depp, Jr., Cleveland, Univ. of Pittsburgh; James M. Diethelm, Toledo, St. Louis Univ.; Everette J. Dunning, Cleveland, Univ. of Pennsylvania; James A. Farley, Chillicothe, Med. College of Va.; Charles G. Fraser, Columbus, Univ. of Rochester; Joseph C. Gallagher, Rossford, Washington Univ.; John R. Haserick, Cleveland, Univ. of Minn.; Raymond H. Hellmann, Jr., Cincinnati, St. Louis Univ.; Shozo Iba, Cleveland, Boston Univ.; Richard A. Jubelirer, Cincinnati, Univ. of Wisconsin.

Lyle W. Kahler, Toledo, Wayne Univ.; James F. Kilduff, Jr., Cleveland, St. Louis Univ.; Mary E. Kinsey, Columbus, Univ. of Kansas; Calvin B.

Kitchen, Delaware, Univ. of Michigan; Aaron H. Kornblau, Cleveland, Univ. of Vienna; Salvatore R. LaTona, Cleveland, Creighton Univ.; William E. Leeper, Jr., Springfield, Duke Univ.; James T. Mayer, Cleveland, St. Louis Univ.; Kevin C. McGann, Cincinnati, St. Louis Univ.; Alan M. McKaig, Springfield, Syracuse Univ.; William O. McNellie, Columbus, Univ. of Pittsburgh; John Edmund J. McSweeney, Cincinnati, Johns Hopkins Univ.; Samuel Morchan, Piqua, Univ. of Basel, Switzerland.

James L. Orbison, Cleveland, Northwestern Univ.; William Ransohoff, Cincinnati, Univ. of Cincinnati; Conyers B. Relfe, Wauseon, Jefferson Med. College; George T. Rich, Toledo, St. Louis Univ.; Charles P. Salyer, Cincinnati, Univ. of Louisville; John R. Sinkey, Toledo, Univ. of Michigan; William A. Stowe, Dayton, Wayne Univ.; Winter T. Varner, Cleveland, Univ. of Pittsburgh; Allen E. Walker, Cleveland, Univ. of Rochester; Watson H. Walker, Columbus, Meharry Med. College; Jacob G. Warden, Cleveland, Northwestern Univ.; William M. Watson, Wooster, Emory Univ.; Jacob Weinberger, Gallipolis, Royal College of Edinburgh, Scotland; Max Yergan, Jr., Cleveland, Columbia Univ.

Rocky Glen Sanatorium Scene of Excellent Eighth District Meeting

Mid-summer meeting of the Eighth Councilor District was held on Thursday, July 8, at Rocky Glen Sanatorium, McConnelsville, with approximately 100 physicians from Southeastern Ohio in attendance.

The program consisted of three addresses by members of the staff of the Cleveland Clinic. Dr. Robert Dinsmore spoke on the subject, "Gallbladder Disease"; Dr. A. Carlton Ernstene on "Coronary Heart Disease"; and Dr. Robert Schneider on "Diabetes".

At the business session an invitation from the Washington County Medical Society for the district to hold its fall meeting at Marietta was accepted. New officers elected were: Dr. Edgar Northrup, Marietta, president, and Dr. Roy M. Meredith, Marietta, secretary.

Following the program, an elaborate buffet supper was served by the sanatorium through the courtesy of Dr. Louis Mark, medical director, and members of his staff.

Arrangements for the meeting and program were handled by Dr. W. D. Nusbaum, Lancaster, and Dr. Fred E. Spangler, Lancaster, retiring president and secretary, respectively.

Among those attending the meeting were Dr. C. P. Swett, Lancaster, Councilor of the Eighth District, and Mr. Charles S. Nelson, executive secretary of the Ohio State Medical Association, Columbus.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SOME WISE ADVICE TO NEW PHYSICIANS (AND OLD ONES)

At the graduation exercises of the New York Medical College, Brig. Gen. George E. Armstrong, deputy surgeon general, U.S. Army, landed a few rights and lefts which are worthy of careful study, first, by medical educators; secondly, by practicing physicians.

Said General Armstrong:

"I recently heard one medical school severely criticized by an individual in whose judgment I repose the utmost confidence. He said: 'That school is making a terrific mistake. It is turning out graduates who believe that they are finished doctors, that they know all there is to know about medicine in all its phases, and finally (this was by far the most serious criticism) they are teaching their students medicine as though what we know today about this most intricate science is the final word and that today's teachings will twenty years from now be equally as true and fully as sound.' We have then, at least one school, thoroughly accepted by the profession at large, and undoubtedly there are others which are teaching a most dangerous doctrine and one which augurs ill for the future of medicine in this country."

As to acquiring the proper attitude toward patients, General Armstrong offered the following wise suggestions:

"One thing which I should like to emphasize most strongly is the proper attitude which we all must take toward those individuals who come to us seeking medical attention. Too many doctors today who are supposed to be practicing medicine fail to recognize that each person who comes to us seeking professional care and advice is a 'patient' and not a 'case.' Without exception the person who is sick, whether the sickness be real or imagined, is frightened, anxious, and apprehensive. All this regardless of the faith that he or she may have in the individual physician or physicians. To disregard this mental state is not only inexcusable but worthy of condemnation. Here is where we come to the most important phase of medical practice—the doctor-patient relationship. Someone recently said that what this country needs is more doctors who will sit down and listen to the patient's story. If you have not already discovered that fact, you will discover it—namely, that to allow the patient to unburden himself of a complete story of his mental or physical illness will in itself be the means of the ultimate cure of many and the decided improvement of the large majority. To minister to the sick the doctor must then not only be professionally well grounded but must be kind, understanding, and sympathetic. I do not infer that the latter should be carried to the point where it might become maudlin. One may be sympathetic without becoming emotional."

The General put the finishing touch to his remarks by advising the graduates about their

community obligations. The following recommendations should be complied with by all doctors—young and old:

"There is an equal and much larger responsibility which we as doctors have toward the community in which we reside and toward the country of which we are citizens. The members of the medical profession form one of the most cultured and best educated groups in the world. As such, our communities and our nation should look to us as counselors and leaders. I do not infer that I recommend members of our profession entering politics as active aspirants for public office, although I am sure that to a degree such would be highly desirable. What I do mean is that every member of a profession should take an active interest in civic problems particularly those which are likely to improve health, to raise standards of living, to prevent crime, and other similar projects. Every doctor should have a very acute interest in those individuals who by election or appointment are going to hold the reins of our Government either at the ward or Federal level. I wonder how many of the almost two hundred thousand registered physicians in our country today even exercise their right to vote? I wonder what percentage accept a 'jury call' without utilizing every effort to avoid such duty? I wonder how many accept membership on citizen committees gracefully and without the thought or expression that 'I am entirely too busy for such affairs?' In other words, how many doctors today are leading or even participating in their responsibility as leading citizens of our country? I am sure that I need not develop further the point which I am endeavoring to make."

D-DAY APPROACHING FOR KICKBACK PARTICIPANTS

The American Medical Association has named a committee to study all phases of rebating, headed by Dr. Frank R. Ober, Boston. It is hoped that the committee will be able to produce a report which will stimulate action toward cleaning up a situation which, unfortunately, has resulted in mighty poor publicity for the medical profession.

Physicians will be interested in the following excerpt from the official bulletin of the Ohio State Pharmaceutical Association on the matters of discounts, rebates and kickbacks, in which sound advice in strong language is given to Ohio druggists (advice, by the way, which physicians, also, would do well to heed):

"The giving of a preferential discount on goods for use or consumption by any individual is not ethical and it is a discriminating practice. It is also a violation of the manufacturer's Fair Trade Contract to give a discount off established minimum prices. Further, customer discounts are something that will not remain

a secret very long because consumers do talk and exchange information so you will find yourself in the middle of a vicious circle. Frankly, we do not believe a physician, dentist, nurse or other professional people are entitled to a discount on articles not directly used in the practice of their profession. If discounts are to be given then the same should be limited only to **your employees** because this is a custom or a generally accepted practice among all types of retailers.

"In the Practical Pharmacy Edition of the Journal of the A. Ph. A. comment was made upon the complaints aired in the American Medical Association Journal that some medical practitioners are splitting fees or receiving "kickbacks" from opticians, suppliers of orthopedic devices and certain pharmacists, and it is pointed out that both the ethics of pharmacy and medicine are being violated wherever such practice exists. We hear talk of the counter-prescribing pharmacist and the dispensing doctor who value the dollar more than their sense of duty to their profession but none of these compare with the pharmacist who gives their doctor friends a "kickback" on either regular or V. A. prescriptions. While we do not believe this a common practice in Ohio we are not naive enough to believe that it is not a possibility. If you have evidence or a belief that this practice does exist or is prevalent in your trading area, then most certainly the matter is important enough to discuss at your local association meetings and to confer about it with your county medical society. To our way of thinking, fee splitting is another racket, it is Un-American and it should be stopped. Also parties engaged in the practice should be exposed and the patient protected against this collusion."

CASE REPORT ON "POTOMAC FEVER"

Did you ever hear of "Potomac Fever"?

Neither had we (at least not by that name), until just recently. It is reported in the May issue of *American Economic Security*, publication of the Chamber of Commerce of the United States, and appears to be more prevalent than some people believe.

Following is the report which is worthy of careful study by members of the medical profession:

"Here is a businessman's definition of an increasingly common malady, afflicting—he thought—some of his fellow delegates on the medical-care panel of the National Health Assembly:

"Potomac fever, an infectious disease particularly prevalent in the Potomac basin; marked by a high social-conscience temperature at all times and by continuing hallucinations that good comes only from Washington, D. C. In a recent, virulent form the hallucinations include the fantasy that good must be done not only to American natives, but to aborigines the world over.

"The businessman admitted his knowledge of the victims' hallucinations was limited. Chiefly,

he said, he had observed sufferers overcome by the obsession of making everyone else unbearably healthy. Sometimes they chant the words 'compulsory health insurance' over and over, he observed. He affirmed his belief, though, that the hallucinations may take other forms.

"There is no effective therapy for Potomac fever, the businessman stated, but—as victims tend to reinfect one another—it is best to keep them apart, if possible, and to avoid anything which might stimulate excited mental activity. Removal to parts distant from the Potomac valley might also prove beneficial, he added."

OHIO'S LOSS WILL BE CALIFORNIA'S GAIN

The announcement that Dr. George T. Harding, Columbus, has accepted the presidency of the College of Medical Evangelists, Los Angeles, has left his many colleagues and acquaintances throughout Ohio with conflicting emotions. All regret that he is leaving Ohio. At the same time they are pleased at the honor which has come to him and are aware of the fine opportunities which are offered him in the Far West.

As a member of The Council of the State Association several years ago and as a member of committees of the Association at various times, Dr. Harding made large contributions to the activities of the organization. Also, he has made large contributions to the work of the Columbus Academy of Medicine; to the many groups and organizations throughout Ohio which he has served in an advisory capacity, representing his specialty of psychiatry and neurology; and to the people of his community and many other parts of the State through the practice of medicine of the highest standard.

Ohio is reluctant to see Dr. Harding leave, but extends to him good wishes and appreciation. California is gaining a physician, scholar, teacher, and citizen of which it will be proud.

EMPLOYABILITY IS THE IMPORTANT POINT

The next time someone throws a lot of Selective Service disability statistics at you, or an audience, in an effort to show that those figures prove we should have a super-duper Federal health insurance program, cite the following, quoted from an article by Dr. Jean Spencer Felton, Oak Ridge, Tenn., which appeared in *Occupational Medicine*:

"While decrying the physical status of rejected candidates for military service, this same school has failed to demonstrate the most important quality possessed by these men, specifically, their employability. Insufficient emphasis has been laid on the worth of these men as capable workers in the industrial scene, where less stringent physical standards will allow this group to become economically sound through

accurate studied job placement. Tight though the labor market was during the war years, hundreds of thousands of men and women workers streamed to industries, performing heretofore unfamiliar tasks, spending long hours in the changing environment of plants being converted to wartime production, living in the crowded areas of boom cities, developing new work technics—all this being done by many with definite physical impairments. That industry can and has used the limited worker has been demonstrated repeatedly, for it is realized 'that there is no such thing as a sub-standard worker under a selective placement program'."

As we have said before, to go on the theory that all boys and girls belong in wheelchairs unless they can meet the high standards of the military is ridiculous. Sure, high health standards should be maintained and everything possible should be done to increase the physical efficiency of all. But, let's keep our sense of values.

INTEREST IN YOUR LOCAL GOVERNMENT IMPERATIVE

More and more Ohio cities—the latest being Columbus and Youngstown—are adopting a local income tax to raise additional funds for operation of the municipal government.

All of which places an additional responsibility on groups of taxpayers, civic organizations—citizens generally—to take a greater direct interest in the activities of their local governmental agencies.

For example, the medical society in local-income-tax cities is obligated to see that the local health department gets a fair shake when the additional money is allocated; to find out whether or not the department is doing the kind of job which entitles it to more money; to advise as to how the funds should be spent.

This kind of direct action by citizens should happen even when state and Federal money is being used. But, when the money comes from local bank accounts, surely those who are footing the bills ought to take an even greater interest in seeing that it is spent wisely.

MEDICAL FEES, LIVING COSTS, AND OVERCHARGING

The cost of living has risen more rapidly than the fees charged by physicians, according to a study made by Frank G. Dickinson, Ph.D., director, Bureau of Medical Economic Research of the American Medical Association, which is a point too often overlooked by the consumers of medical service.

At the same time, this situation should not be used as an excuse for excessive charging—a practice which is becoming too prevalent in some communities.

The following words of advice in the *Detroit*

Medical News should be heeded by every physician:

"The attitude of the public toward the medical profession will be greatly improved when some physicians and surgeons learn that excessive charges for personal services reflect unfavorably on the entire profession—rather than just on him as an individual."

AUSTRALIA SENSES THE HANDWRITING

Australia has a pharmaceutical benefits act which provides free medicine to any citizen if the medicine is prescribed by a doctor on specific forms furnished by the government and within the restrictions of a formulary drawn up by a government committee.

Reports from "down under" indicate that the folks are not too happy about this legislation as they feel that it is a step toward regimenting the medical profession as the socialist regime had done in England.

Another example of the boring from within and offering of government medicine in dribbles, the things which Mr. America had better keep in mind as the politicians offer piece-meal programs, seemingly harmless in themselves but which add up to a complete program at the finish.

TAKE AFTER EACH MEAL AND AT BEDTIME

To those who always find fault—and no good—in the activities of their local, state, or national medical societies, we recommend the following, after each meal and at bedtime, stolen from the Public Relations Bulletin of the Medical Society of the State of Pennsylvania:

"A horse can't pull while kicking,
This fact I merely mention—
And he can't kick while pulling,
Which is my chief contention."

GOOD REFERENCE DATA ON GROUP PRACTICE

Physicians interested in forming a group practice should get a copy of an annotated bibliography of group practice, recently issued by the Bureau of Medical Economic Research of the American Medical Association, Chicago. It is full of references to which interested physicians can write for information ranging from the basic policies of group practice to material which should be included in formal contracts setting up the group. Since the advantages or disadvantages of group practice, the legal angles, ethical phases, etc., are still debatable questions, those contemplating organizing or joining a group should be well informed before acting. By consulting the more reliable references cited, they can obtain a wealth of valuable data, based in many instances on actual experiences.

Do You Know? . . .

In the National Traffic Safety Contest conducted by the National Safety Council in 1947, Cleveland placed first in cities of 500,000 or over and Lakewood captured second place for cities in the 50,000-100,000 group. The grand award for the safest state went to Connecticut.

* * *

Action of Geauga County physicians in voting to meet operating deficits on a pro-rata basis prevented the closing of Corey Hospital, Chardon. Local officials hope to place a bond issue for a new hospital on the ballot in November.

* * *

Robert W. Elwell, Executive Secretary of the Toledo Academy of Medicine, has been named chairman of the summer survey of local health needs made by the Toledo Council of Social Agencies.

* * *

Dr. I. B. Harris, Columbus, was feted recently by over 100 of his professional colleagues, in celebration of his 50 years of active service on the staff of St. Francis Hospital. The affair was initiated and sponsored by the Sisters of the Poor of St. Francis. Toastmaster for the dinner was Dr. C. A. Doan, Dean of the Ohio State University College of Medicine. Speakers included Dr. Howard L. Bevis, President of O.S.U.; J. A. Meckstroth, editor of the *Ohio State Journal*; and Dr. Joseph Price, Columbus.

* * *

The recently renovated surgical department of St. Alexis Hospital, Cleveland, has been named the Follansbee Pavilion of Surgery, in memory of the late Dr. George E. Follansbee, former chief of staff, who died in 1945. Dr. Follansbee was a former president of the Ohio State Medical Association and the Cleveland Academy of Medicine.

* * *

Dr. James R. Miller, Hartford, Conn., a member of the Board of Trustees of the American Medical Association, was one of three official delegates appointed by President Truman to attend the first meeting of the World Health Assembly in Geneva, Switzerland, June 24. The other delegates were: Dr. Thomas Parran, former surgeon-general of the U. S. Public Health Service, and Dr. Martha M. Elliott, associate chief of the U. S. Children's Bureau.

* * *

Stanley R. Mauck, executive secretary of the Columbus Academy of Medicine and executive director of the Columbus Bureau of Medical Economics, has been named an alumni trustee of Ohio Wesleyan University, Delaware.

The record of the 80th Congress in the field of medical and health legislation was discussed by George H. Saville, Director of Public Relations of the Ohio State Medical Association, at an evening meeting of the Lancaster Exchange Club, July 13.

* * *

The labor dispute between Chicago job printers and the International Typographical Union which began March 8, 1948, ended on June 29, with the signing of a new 18 months' contract. The *Journal of the A.M.A.* went back to normal print with the July 24 issue.

* * *

The William E. Lower prize, given at the Cleveland Clinic each year for the outstanding thesis among third-year fellowship students, has been awarded to Dr. Alys H. Lipscomb, who based her thesis on "Incidence of Various Types of Essential Hypertension as Related to Evaluation of Successful Therapy."

* * *

Hebron recently honored Dr. George N. Brown with a community celebration upon the completion of his 50th year in practice there. Speakers included Dr. Frank Clemson, Thornville, a classmate; Dr. Chester P. Swett, Lancaster, Eighth District Councilor for the Ohio State Medical Association; and Dr. L. H. Miller, Newark, secretary of the Licking County Medical Society.

* * *

Recent addresses by Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association, include the presentation of greetings from the medical profession to those who attended the annual meetings of the Ohio State Pharmaceutical Association in Cincinnati and the Ohio State Nurses' Association in Columbus.

* * *

Dr. A. Carlton Ernstene has been appointed head of the Division of Medicine at the Cleveland Clinic. A member of the Clinic staff since 1932, he has been head of the Section on Cardiovascular Disease for many years. Dr. Ernstene is president of the Cleveland Cardiovascular Society and is a director of the Academy of Medicine of Cleveland.

* * *

Practical nurses now may be hired by government agencies under a new civil service job classification, Practical Nurse Series SP-676-O. According to *Hospitals*, practical nurse duties in the government services will involve, primarily, giving bedside nursing care to subacute, convalescent and chronically ill patients, and assisting professional nurses.

Veterans Administration . . .

Outpatient Facilities Aid 202,271 Veterans With Service-Connected Disabilities in 22-Month Period; Fees Total More Than Two Million

BRANCH Office No. 6 of the Veterans Administration, Columbus, has furnished some interesting data regarding the Ohio veterans' medical care program sponsored jointly by the Ohio State Medical Association and the Veterans Administration which has been in operation since mid-Summer of 1946.

During the period August 1, 1946, to June 1, 1948, a total of 202,271 veterans whose disabilities were adjudicated as service-connected received medical care through out-patient facilities of the Veterans Administration in Ohio or from Ohio fee-basis physicians. Veterans with non-service-connected disabilities are not entitled to out-patient medical care under existing Veterans Administration laws and regulations.

Of the 202,271 veterans receiving out-patient medical care, 58,330 received care from fee-basis physicians in the Cleveland area and 30,636 from fee-basis physicians in the Cincinnati area. Those receiving medical care from Veterans Administration out-patient facilities in the Cleveland area totalled 66,259. Those receiving care from Veterans Administration out-patient facilities in the Cincinnati area totalled 47,044. The totals show that 88,968 veterans were treated by fee-basis physicians throughout the State and that 113,303 veterans received medical care at Veterans Administration out-patient facilities.

During the period August 1, 1946, to June 1, 1948, fee-basis physicians in Ohio received fees from the Veterans Administration totalling \$2,239,109. Of this amount, \$889,160 were received by fee-basis physicians treating veterans under the jurisdiction of the Cleveland area office; \$1,349,949 by physicians treating veterans under the jurisdiction of the Cincinnati area office.

During the period July 1, 1946, to June 1, 1948, a total of 29,234 veterans—service-connected and non-service-connected—received hospital care at Veterans Administration hospitals in Ohio. No figures are available on the number hospitalized in private contract hospitals, but the number probably is small.

No breakdown is available between hospitalized veterans with service-connected disabilities and those with non-service-connected disabilities. However, current records of the Veterans Administration show that approximately 69 per cent of patients in Veterans Administration hospitals in this area were admitted for non-service-connected disabilities.

The number of veterans of World War I and

World War II in Ohio as of June 1, 1948, is estimated at 1,000,930 of whom 796,545 are World War II veterans.

No reliable estimate is available of the number of Ohio veterans with service-connected disabilities. However, the records show that as of May 31, 1948, 101,272 World War II and 26,418 World War I veterans and other veterans in Ohio were receiving disability compensation.

* * *

Veterans of peace-time service in the regular military or naval establishment, who served six months or more and who received honorable discharges, are now entitled to certain presumptions of service-connection for compensation purposes where tropical diseases become manifest after discharge, Veterans Administration has announced.

These presumptions, heretofore accorded only to wartime veterans, result from Public Law 748 of the last Congress. This law provides that a peace-time veteran who contracts a tropical disease within one year from discharge, or within the accepted incubation period for the particular disease, will be deemed to have incurred the disease in service, unless there is clear evidence to the contrary.

The Act also writes into law certain presumptions for wartime veterans which previously were granted under administrative authority. It further extends the list of chronic and tropical diseases to which such presumptions shall apply.

* * *

Veterans Administration has inaugurated a comprehensive follow-up program, designed to enhance and prolong the effects of hospital treatment, among the thousands of veterans suffering from tuberculosis.

More than 13,000 veterans suffering from tuberculosis now are under the care of V. A. A total of 80,763 veterans are receiving compensation or pensions for tuberculosis.

Cooperating in the program are all of V.A.'s 126 hospitals and 70 regional offices.

Dr. John Barnwell, chief of Tuberculosis Service in the Department of Medicine and Surgery, said V.A.'s follow-up program is designed to discover relapses among tuberculosis sufferers early so that further treatment may be instituted promptly. It further is designed to help prevent advanced disease and thus contribute toward the

safeguarding of others through the control of communicable tuberculosis.

* * *

Appointment of Dr. Augustus Thorndike, prominent Boston, Mass., surgeon, as director of Veterans Administration Prosthetic and Sensory Aids Service, effective July 1, 1948, was announced recently.

* * *

Dr. Emmett L. Hooper, 59, superintendent of the Dayton State Hospital for the past 21 years, has been appointed assistant chief in charge of the Neuropsychiatric Division for the Veterans Administration in Ohio, Michigan, and Kentucky, it was announced recently by Ralph H. Stone, Deputy Administrator for the tri-state branch office in Columbus.

Dr. Harry Luidens, Chief of the Division since April, 1946, has been transferred to the Chillicothe V. A. Hospital as assistant clinical director in charge of the hospital's residency program.

* * *

Following is the text of a communication sent to all Veterans Administration regional managers in Ohio, Michigan, and Kentucky by Ralph H. Stone, deputy administrator, in charge of Branch Office No. 6, warning that "solicitation by part-time V. A. physicians and dentists, or any favoritism to them in the authorization of fee basis out-patient medical and dental examinations or treatment, cannot be tolerated":

1. An investigation was conducted recently at one V. A. Regional Office into the activities of dentists formerly employed on a part-time basis in that office.

2. The evidence developed in this investigation strongly indicates that there has been solicitation on the part of some part-time professional employees to induce veterans to request their services for fee basis out-patient treatment.

3. Solicitation by part-time V. A. physicians and dentists, or any favoritism to them in the authorization of fee basis out-patient medical and dental examinations or treatment, cannot be tolerated.

4. Outpatient examinations and treatments will be authorized in accordance with existing instructions to participating physicians and dentists in an impartial and equitable manner. Selection of the place of rendition of out-patient examinations and treatments will be made on the following basis:

- (a) At a V. A. Office if feasibly available;
- (b) At the office of a participating physician or dentist, selection of the participating physician or dentist to be the free and unsolicited choice of the veteran;
- (c) No fee basis cases will be authorized to part-time employees of the V. A. without strict compliance with sub-paragraph (b) above, unless the part-time employee is the only available specialist in the veteran's community and must of necessity be used.

5. Nothing in this letter should be construed as changing existing instructions and regulations with reference to the limitation of amount of

fees which may be paid to a participating physician or dentist during a fiscal year. It is to emphasize the importance of a fair distribution of fee basis authorizations, and to stress the fact that no solicitation, collusion or other indication of partiality toward any participating physician or dentist will be countenanced.

* * *

Improved techniques in the care of mentally-ill veterans are enabling Veterans Administration, for the first time in many years, to discharge about as many patients as it admits to its neuro-psychiatric hospitals. Generally admissions and requests for care exceed the number of patients discharged.

However, during a recent ten-month period (July, 1947, through April, 1948) 1,060 more neuropsychiatric patients were discharged from hospitals than were admitted. During this period, a total of 51,210 patients were admitted for care and 52,270 were discharged as improved or cured.

For the 22-month period from July, 1946, through April, 1948, a total of 107,579 patients were admitted to hospitals for treatment, compared with 106,694 discharges, or only 885 more admissions than discharges.

This is an indication that improved methods of care and establishment of more mental hygiene clinics for out-patient treatment have enabled V. A. to keep its hospital load of mentally-ill from increasing substantially.

* * *

Appointment of Miss Olga C. Benderoff, of Cleveland, as acting chief in charge of the nursing division for the Veterans Administration in Ohio, Michigan, and Kentucky was announced recently.

In assuming the branch office post in Columbus, she succeeds Miss Frances Hellman, who has transferred to Denver, Colorado, as V. A. chief nurse.

During World War II, Miss Benderoff served overseas as a lieutenant colonel in the Army Nurses' Corps. She is a member of the American Nurses Association, National League of Nursing Education, and Alumnae Association of Frances Bolton School of Nursing.

Health Education Workshop

A Workshop on School Health Education, for teachers, nurses, school administrators, and physicians, was held on the Ohio State University campus July 6-24 under joint sponsorship of the College of Medicine and College of Education.

Dr. Carl A. Wilzbach, Cincinnati, Chairman of the Committee on School Health, Ohio State Medical Association, was a program participant.

Dr. George M. Wheatley, New York City, nationally known school health authority, was one of the consultant staff of experts.

In Memoriam . . .

Ernest Edward Bishop, M. D., Cincinnati; University of Cincinnati College of Medicine, 1919; aged 54; died June 13; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Bishop served his entire period of practice in Cincinnati where for the past several years he was tuberculosis coordinator for the Hamilton County Public Health Service. Formerly he was superintendent of the Dunham Hospital. Dr. Bishop was a member of the Trudeau Society, Alpha Kappa Kappa fraternity, and the Masonic Lodge. Surviving are his widow, two sons, a daughter, and two brothers.

John C. Blinn, Sr., M. D., Bellefontaine; Cleveland University of Medicine and Surgery, 1884; aged 92; died June 14; former member of the Ohio State Medical Association and the American Medical Association through 1935. Dr. Blinn practiced medicine for a total of 64 years, most of which he served in Logan County. He retired from active practice only a few years ago. He was an elder in the Presbyterian Church. Surviving are his widow, two daughters, two sons, including Dr. John C. Blinn, Jr., of New Philadelphia, and a brother.

Richard Lorenzo Brown, M. D., Gloster, Miss.; Cincinnati College of Medicine and Surgery, 1889; aged 81; died June 18; former member of the Ohio State Medical Association and the American Medical Association during 1946. Dr. Brown spent most of his life of practice in Mechanicsburg and other cities in west-central Ohio.

William Thomas Corlett, M. D., Cleveland; University of Wooster Medical Department, Cleveland, 1877; aged 94; died June 11; member of the Ohio State Medical Association and the American Medical Association; Diplomate of the American Board of Dermatology and Syphilology; Professor Emeritus in dermatology at Western Reserve University School of Medicine. Dr. Corlett was internationally known, especially in the field of dermatology. On several occasions he lectured and held clinics on the continent of Europe and in England where he was made a fellow of the Royal Society of Medicine. His writings include many contributions to medical journals and a number of published books. Organizations in which he took a part as well as enterprises in which he pioneered are too numerous to list. Dr. Corlett retired from active practice in 1925. Surviving are three daughters and a son.

Willis E. Elder, M. D., Columbus; College of Physicians and Surgeons of Baltimore, 1895; aged 81; died June 14; former member of the Ohio

State Medical Association and the American Medical Association through 1932. Dr. Elder served a long period of practice in Chandlersville and Mt. Sterling. He was assistant chief medical examiner of the Ohio State Industrial Commission from 1918 until his retirement in 1939. Surviving are two daughters, and a brother. He was a member of the Presbyterian Church.

Lucia Kemp Feighner, M. D., Bucyrus; Fort Wayne College of Medicine, 1891; aged 85; died June 24; former member of the Ohio State Medical Association and the American Medical Association through 1938. After several years practice in Cincinnati, Dr. Feighner moved to Bucyrus where she continued until her retirement about 10 years ago. She was a member of the Presbyterian Church and the Order of Eastern Star.

Wilgus Alexander Holman, M. D., London, Jefferson Medical College of Philadelphia, 1923; aged 50; died June 10; member of the Ohio State Medical Association and the American Medical Association; vice-president of the Madison County Medical Society from 1932 through 1935; secretary-treasurer in 1938; president in 1940; chairman of the legislative committee in 1935, 1941 and 1942; delegate to the Ohio State Medical Association in 1938, 1940, 1941, 1943 and 1948. Dr. Holman practiced medicine in London for the past 24 years. He was active in civic affairs of the community especially in the field of education and athletics. He was a member of the Madison County Board of Health, the Lions Club and the Masonic Lodge. Surviving are his widow, a son and a daughter.

Robert Armstrong Kidd, Sr., M. D., Columbus; Ohio Medical University, Columbus, 1901; aged 72; died June 19; member of the Ohio State Medical Association and a Fellow of the American Medical Association; member of the American Psychiatric Association. Dr. Kidd was president and superintendent of the McMillen Sanitarium for the past 45 years. His pioneering achievements in the field of neurology and psychiatry included work with the *Journal of Nervous and Mental Diseases* and the National Association of Private Psychiatric Hospitals. He belonged to several Masonic orders, the Exchange Club, Nu Sigma Nu and the Methodist Church. Surviving are three daughters and three sons, including Dr. Robert A. Kidd, Jr., also of Columbus.

William Edgar Lower, M. D., Cleveland; University of Wooster Medical Department, 1891; aged 81; died June 17; member and Past-President of the Ohio State Medical Association and a

Fellow of the American Medical Association; a Diplomate of the American Board of Surgery and of the American Board of Urology; member of the American Surgical Association, the Southern Surgical Association, the American College of Surgeons, the Society of Clinical Surgery, the American Association of Genito-Urinary Surgeons, the American Urological Association and the Clinical Society of Genito-Urinary Surgeons. Dr. Lower's active practice covered a period of approximately 56 years in Cleveland where he was one of the founders of the Cleveland Clinic. He was in the Army Medical Corps during both the Spanish-American War and World War I. Surviving are his widow and a daughter.

John Clarence McGrath, M. D., Nelsonville; Ohio Medical University, Columbus, 1898; aged 78; died June 20; former member of the Ohio State Medical Association and the American Medical Association through 1932. Dr. McGrath practiced in Jobs, Carbon Hill as well as in Nelsonville where he maintained his practice until his retirement several years ago. He was a member of the Elks Club. Surviving are his widow and a daughter.

Simon Warren Reichard, M. D., Dayton; Medico-Chirurgical College of Philadelphia, 1901; aged 70; died June 19; member of the Ohio State Medical Association and the American Medical Association. Dr. Reichard practiced medicine since 1936 in Dayton where he was chief medical officer for the Veterans Administration. He was a member of the Methodist Church, several Masonic orders, the American Legion, and the Veterans of Foreign Wars. Surviving are his widow, four daughters, and a sister.

Howard Francis Schell, M. D., Cincinnati; University of Michigan Homeo-Medical School, 1904; aged 68; died June 16; former member of the Ohio State Medical Association and the American Medical Association through 1930. Dr. Schell had been a general practitioner in Cincinnati for 25 years prior to his retirement about 10 years ago. Surviving are his widow and two brothers.

John Frederick Vick, M. D., Toledo; University of Michigan Medical School, 1923; aged 59; died June 7; former member of the Ohio State Medical Association and the American Medical Association through 1939. Dr. Vick was a life resident of Toledo where he practiced his profession since completion of his medical education. Surviving are a brother and three sisters.

Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was honored by Hiram College Alumni, Hiram, Ohio, when he was awarded the Alumni Award for Distinguished Service.

Medical Executives Conference Elects Nelson Chairman

Charles S. Nelson, executive secretary of the Ohio State Medical Association, was elected chairman of the Medical Society Executives Conference at the second annual meeting of the national organization in Chicago on June 23.

The conference is composed of approximately 100 executive secretaries, other executives and assistants of county, state regional, and national medical societies. All persons in full-time executive positions in medical societies, whether physicians or laymen, are eligible for membership.

The purpose of the organization is to stimulate closer cooperation between executive workers in the medical field and to bring them together for exchange of ideas and discussion of common interests.

James E. Bryan, executive officer for the Medical Society of New Jersey, was named to the newly created office of chairman-elect and William F. Irwin, executive secretary of the Philadelphia County Medical Society, was elected secretary. Dr. George F. Lull, secretary and general manager of the American Medical Association, and Mac F. Cahal, executive secretary of the American College of Radiology, were chosen members of the executive committee.

Opinions of Attorney General

Following are recent opinions rendered by Attorney General Hugh S. Jenkins:

Opinion No. 3067: Under the provisions of Sec. 2855-17, General Code, a coroner is authorized to appoint one or more assistant coroners, and under the provisions of Sec. 9, General Code, he may take from each of said assistants a bond conditioned for the faithful performance of the duties of said deputy, and may cause the expense of the premium of said bond if signed by a surety company, to be paid out of the county treasury pursuant to the provisions of Sec. 9573-1. Bonds given by the assistants to the coroner may be made payable either to the State of Ohio or to the coroner himself.

Opinion No. 3368—(1) "Hospital Care," as the same is defined in Sec. 3391, General Code, does not include care in rest homes or nursing homes. (2) Payment for the care and treatment of permanently disabled indigent persons in rest or nursing homes is the obligation of the county of residence of such persons and may not be made from poor relief funds. (3) The cost of the care and treatment given to temporarily disabled indigent persons in rest or nursing homes may not be paid from poor relief funds if such persons are not homeless. (4) The cost of care and treatment furnished in rest or nursing homes to indigent homeless persons who are temporarily disabled may be paid from poor relief funds.

Medical Board Examinations . . .

Licenses To Practice Medicine and Surgery Sought by 241 Graduates; 33 Take Osteopathic Test, While 127 Apply for Limited Practice

LICENSES to practice medicine and surgery in Ohio were sought by 241 medical school graduates at the examinations of the State Medical Board, held in Columbus, June 21-24.

Seven applicants were examined in osteopathic medicine and surgery. In addition 14 took special examinations, and 12 sought endorsement of licenses.

Examinations for certificate of limited practice were taken by 32 chiropractors, 15 mechanotherapists, 32 chiropodists, 10 cosmetic therapists, and 38 masseurs.

Results of the examinations will be announced by the Board at a meeting to be held in Columbus, August 10.

Following are the written questions asked those who were examined for licenses to practice medicine and surgery:

CHEMISTRY

1. Discuss the nature of histamine, its occurrence and significance in normal metabolism and diseases.
2. Discuss the composition of bile. Give the known facts concerning the biological function and origin of each of the principal constituents of organic nature.
3. Discuss two chemical factors that are important in the formation of bone.
4. Under what conditions may sufficiently large amounts of chlorides be lost from the body to be a matter of concern? Discuss.
5. Rosenfelt has stated that "the fats burn in the fire of the carbohydrates". Explain the significance of this statement.

ANATOMY

1. Give anatomy of thyroid gland, its relations, blood and nerve supply.
2. Describe the clavicle and scapula, their attachments and articulation.
3. Name the foramina in floor of skull and what passes through them.
4. Describe the blood supply of the stomach.
5. Describe the structures involved in (a) inguinal hernia; (b) femoral hernia.

PHYSIOLOGY

1. Discuss the functions of the thyroid gland.
2. What is glucose tolerance?
3. What is myotonia?
4. What are the factors affecting cardiac contraction?
5. How is equilibrium maintained in the human?
6. What are the functions of: (a) the ciliary muscle; (b) fascia lata; (c) ptyalin; (d) The S-A node; (e) endolymph.
7. What are the functions of the spleen?
8. What are the factors that contribute to increased blood pressure.
9. What are the effects of hypothermia,
10. What is the effect of the adrenal cortex hormone on the blood-sugar level?

PATHOLOGY

(Answer any 10 questions)

1. Describe the pathology found in Laennec's cirrhosis of the liver and discuss the probable etiology.
2. Describe the pathology found at autopsy following death from coronary occlusion.
3. What are usual findings at autopsy after death from pulmonary embolism (a) death after a few hours; (b) after 48 hours?

4. Discuss the pathology which may result from calculi in the gall bladder.
5. What are the pathologic findings after death from pyelonephritis?
6. Give the different findings in the bone marrow in pernicious anemia and myeloid leukemia.
7. Give the varieties of cancer of the breast which may occur and state the usual routes and seats of metastasis.
8. Discuss the usual pathology found after death from Addison's disease and give the areas and character of pigmentation often occurring.
9. What is edema? Discuss the mechanism of its occurrence in (a) cardiac decompensation; (b) nephritis; (c) hepatic cirrhosis.
10. Name the glandular dysfunction causing (a) acromegaly; (b) tetany; (c) cretinism; (d) diabetes.
11. Describe the intestinal lesions of typhoid fever and explain how the location of the infective agents in these areas may be active in the spread of the disease in the community.
12. Describe the local lesion of tularemia; give the active agent and tell how it usually gains entrance into man and how this may be guarded against.

DIAGNOSIS

1. Give signs and symptoms of bronchogenic carcinoma.
2. Give subjective complaints of diffuse aneurism of abdominal aorta.
3. Detail history and findings that would differentiate so-called pernicious anemia from aplastic anemia.
4. Differentiate symptoms and physical findings in tabes dorsalis and paresis.
5. In what conditions would you find leukopenia and eosinophilia with platelet count under 90,000 and 10% reticulocytes?
6. Name three conditions that may cause ascites, anasarca and paraplegia?
7. Are there any different physical findings in lobar pneumonia, virus pneumonia and broncho pneumonia? if so, describe them.
8. What do you understand by Herxheimer, anaphylactic and exfoliative dermatitis reactions?
9. Give findings in histoplasmosis, destruction of body of pancreas and infection of kidney by tubercle bacilli.
10. What do you understand by intermittent claudication, hemophilia, and hemolytic blood condition?

PREVENTIVE MEDICINE AND HYGIENE

1. Give adequate directions and procedure for the care and eradication of trench mouth.
2. How would tinea capitis be recognized and how prevented from spreading?
3. Give material to be used and frequency of use in complete program for immunization against diphtheria, pertussis and typhoid fever.
4. Outline an adequate program of inspection and control of food-handlers.
5. What points should be made in periodic health examinations for the best results in preventing disease?

MATERIA MEDICA AND THERAPEUTICS

1. Define (a) alkaloids; (b) glycosides.
2. Explain the action of anti-histamine agent.
3. Give the pharmacologic classifications of cathartics from the standpoint of mechanism of action.
4. Give the treatment of heat stroke (heat retention).
5. Explain the following effects of digitalis when given to a patient with congestive heart failure: (a) Loss of weight; (b) Loss of appetite.
6. (a) Write a complete description for a diuretic drug. (b) Give mechanism of action.
7. Give the treatment for penicillin reaction.
8. Give the treatment of chronic lead poisoning.
9. Give the drugs used in the treatment of tetany and the mechanism of their action.
10. Give the treatment of pulmonary embolism.

BACTERIOLOGY

1. Name two organisms which may cause dysentery. Describe each and give procedures for obtaining specimens for diagnosis.
2. Name two diseases against which it is advisable to

immunize children and ages preferred for such procedure.

3. Name the animal reservoirs of the following diseases:
 - (a) undulant fever
 - (b) tularemia
 - (c) psitticosis
 - (d) bubonic plague
 - (e) Rocky Mountain fever
- How are these diseases conveyed to man?
4. Give the laboratory methods of diagnosing typhoid fever in (a) the first week; (b) after the first week.
5. Give the cause, morphology and culture characteristics of the gas gangrene organism.

OBSTETRICS AND GYNECOLOGY

1. Outline proper pre-natal care.
2. What role does the rh factor play in obstetrics?
3. Give symptoms, causes and treatment of ectopic gestation.
4. Outline treatment of acute salpingitis.
5. Give causes and treatment of sterility.

SURGERY

1. Give the indications for and principles underlying the surgical treatment of varicose veins of the lower extremities.
2. What is the significance of bleeding from the nipple in the adult female? Explain the management of such a case. (Omit detailed operation technic).
3. Discuss the usual causes of non-union of fractures and indicate treatment.
4. Discuss deep cervical suppuration under the heading of (a) etiology; (b) zones of spread; (c) choice of anaesthetic; (d) surgical treatment.
5. Discuss the etiology, diagnosis and treatment of spontaneous collapse of the lung.

PRACTICE

1. Discuss the symptoms, clinical course and complications of Paget's disease.
2. Give etiology and symptoms of anterior poliomyelitis.
3. Give symptoms and complications of multiple sclerosis.
4. Describe symptoms and signs of virus pneumonia.
5. Give symptoms and complications of malaria.

SPECIALTIES

1. Define nystagmus; iritis; glaucoma.
2. Define and treat scabies; impetigo.
3. Give differential diagnosis of erysipelas and scarlet fever.
4. Describe an epileptic seizure and differentiate it from an hysterical attack.
5. What is the Babinski sign? What does it denote?

COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22, 1949.

American Medical Association Interim Session, St. Louis, Nov. 30-Dec. 3.

American College of Physicians, Annual Session, New York City, March 28-April 1, 1949.

American Congress of Physical Medicine, Washington, D. C., Sept. 7-11.

American Public Health Association, Boston, Mass., Nov. 8-12.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 8.

Second Councilor District Post-Graduate Day, Springfield, Sept. 29.

Sixth Councilor District Post-Graduate Day, Mayflower Hotel, Akron, Oct. 13.

General Practice Course

A review course in general practice will be given by the staff of Saint Luke's Hospital, Cleveland, Sept. 13-18. The course is designed to cover recent advances in various subdivisions of general practice. Further information may be obtained by writing The Postgraduate Committee, Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland 4.

Buckeye News Notes . . .

Ashtabula—Dr. and Mrs. P. J. Collander celebrated their 45th wedding anniversary in June.

Cardington—Dr. E. C. Sherman, after 52 years of practice, announced his retirement effective July 1.

Cincinnati—The Cincinnati Society of Dermatology and Syphilology sponsored a conference on histopathology in May at the General Hospital. Guest speaker was Dr. Hamilton Montgomery of Rochester, Minn.

Cleveland—Upon his retirement as professor of obstetrics and gynecology, Western Reserve University School of Medicine, Dr. Arthur H. Bill was honored at a dinner given by fellow physicians.

Columbus—Dr. Morse F. Osborn retired this summer as a member of the Ohio State University's student health service with which he has been associated for 20 years.

Columbus—Dr. Beecher L. Smith left Columbus July 1 for a seven months postgraduate course in advanced urology at the James Buchanan Brady Urological Foundation of the New York Hospital and Cornell Medical Center.

Columbus—Dr. Robert M. Zollinger was named chief of staff at St. Francis Hospital to succeed Dr. Bruce K. Wiseman.

Crystal Springs—Dr. Max Haas of Massillon was guest speaker at a meeting of the Crystal Springs Grange. He discussed the heart.

Dayton—Dr. Franklin I. Shroyer of Dayton won second prize in the Mississippi Valley Medical Society essay contest for his essay, "Cytological Diagnosis of Abnormal Growth in the Female Pelvis." Dr. Irving B. Brick, Georgetown University School of Medicine, won first place.

Edon—Dr. O. H. Nihart attended a reunion of the Starling Medical College, class of 1898 in Columbus on June 11.

Gallipolis—Dr. Francis W. Shane was re-appointed Gallia County health commissioner for a period of two years.

Greenville—Dr. Luther E. Cupp of Arcanum, commander of the Third American Legion District, presided at a recent district convention.

Lima—Dr. Edward B. Young recently was appointed to the city board of health.

Malta—Dr. Henry Bachman received an award in Chicago for his pen and ink drawing of "Rocky Glen Sanatorium by Moonlight," which he entered in the art exhibit at the American Medical Association Annual Session.

Mansfield—Dr. Harry Wain, formerly of Dayton, is the new Mansfield-Richland county health commissioner.

Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

Changes in the constitution of the Butler County Medical Society proposed by the Council of the Society were reported in the June issue of the society's bulletin. The changes will be voted upon by members at the September meeting.

CLINTON

Special speaker at the regular meeting of the Clinton County Medical Society on July 6 was Dr. Homer D. Cassel of Dayton who spoke on "Diseases Simulating Gallbladder Disease." A discussion was led by Dr. Kelley Hale.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

The Clark County Medical Society is making preparation for the Second District meeting to be held Sept. 29 at the Springfield Country Club. Technical exhibits will be features of the meeting. On June 30 members of the society held an outing and dinner at the Van Dyke Club in Mechanicsburg.

MONTGOMERY

The General Practice Section of the Montgomery County Medical Society was scheduled to hold its third annual picnic on July 28 at Circle Park in Dayton. Outdoor activities and a buffet dinner followed by evening's entertainment were all features on the program.

Dr. H. D. Cassel was named president-elect of the Montgomery County Medical Society at the annual meeting June 2. Other officers elected were Dr. H. R. Huston, vice-president, Dr. Paul Troup, secretary, Dr. M. D. Place, treasurer, and Dr. A. D. Cook, trustee. Dr. M. D. Prugh was named delegate and Dr. Lynne E. Baker alternate to the Ohio State Medical Association.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

PORTAGE

Dr. William Forsythe of Cleveland spoke on "Diagnosis, Treatment and Prognosis of Carcinoma of the Prostate," at the June 3 meeting of the Portage County Medical Society at Ravenna.

STARK

The Stark County Medical Society closed its season's activities at an outing with the Woman's

Auxiliary. The affair was held at the Brookside Country club on June 23.

Seventh District

(COUNCILOR: R. J. FOSTER, M.D., NEW PHILADELPHIA)

BELMONT

At the June 10 meeting of the Belmont County Medical Society, Dr. A. C. Ernstene of Cleveland spoke on "Coronary Heart Diseases." Dr. Walter B. Lacock, chief of the Cancer Division, Ohio Department of Health, spoke on cancer.

TUSCARAWAS

The Tuscarawas County Medical Society met June 10 at the Stone Creek American Legion Post, where a talk was given by Dr. Max Shawewer, Canton, on "Progress in Laboratory Diagnosis." He illustrated his talk with pictures using the society's new projector.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M.D., PORTSMOUTH)

SCIOTO

"Current Concepts of Orthopedics" was the topic of a talk by Dr. Francis Scott of Huntington, W. Va., at the July 12 meeting of the Hempstead Academy of Medicine in Portsmouth.

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

CUYAHOGA

Chosen on the basis of faithfulness, leadership, and progress in nursing, ten student nurses from ten hospitals in Greater Cleveland received awards of twenty-five dollars from the Woman's Auxiliary to the Academy of Medicine of Cleveland. It was the first time such awards were made. The presentation of the money took place at a tea at the Music School Settlement. Mrs. S. C. Lind was chairman of the awards committee. Selections were made in most cases by the faculty and supervisors of the nursing schools, but some of the winners were chosen by their classmates. Considered in making the choices were faithfulness, dependability, loyalty, cheerfulness, assurance, and patients' reaction to the student nurse.

FAIRFIELD

Mrs. William D. Monger, new president of the Woman's Auxiliary to the Fairfield County Medical Society, and fellow officers were installed by Mrs. Chester Swett, director of the Eighth District, following a dinner at the Lancaster

Country Club. Mrs. Monger has in her official family, Mrs. W. D. Nusbaum, vice-president; Mrs. Fred E. Spangler, secretary; Mrs. Carl W. Brown, treasurer. Mrs. F. D. James is president-elect. Reports of the past year were given by committee chairmen, after which Mrs. Joseph Geer, historian, reviewed the Auxiliary's activities for the past twelve months. Mrs. G. S. Rodabaugh, retiring president, presided.

HARDIN

The Woman's Auxiliary to the Hardin County Medical Society met at the Sunset Supper club for the last meeting until September. Thirteen members were present at the meeting which was presided over by the new officers: Mrs. Robert H. Zeis, president; Mrs. Albert Sage, vice-president; Mrs. H. R. Johnson, secretary; and Mrs. E. P. Clinger, treasurer. Mrs. S. P. Churchill and Mrs. Zeis told of the tea given by the Auxiliary to the Lucas County Academy of Medicine honoring Mrs. E. B. Gillette, president of the State Auxiliary. On July 5 the Auxiliary sponsored a booth at the auction sale for the benefit of the Hardin Memorial Hospital.

JEFFERSON

Jefferson County now has another organization in its family of distinctive women's groups. With the gathering of thirty wives of medical doctors in Ohio Valley Hospital the Woman's Auxiliary to the Jefferson County Medical Society was formed after District Director Mrs. D. H. Downey of Dover presented the purpose, aims and need of such a specific health group. The first officers are: Mrs. Carl Goehring, president; Mrs. W. S. Puncheon, Sr., president-elect; Mrs. W. A. Cunningham, vice-president; Mrs. L. J. Kerschgens, secretary; and Mrs. David Greenberg, treasurer. Also present to launch this new auxiliary were Mrs. E. Benjamin Gillette, Toledo, state president, Mrs. C. W. Kirkland, Bellaire, president-elect, and Mrs. Harold K. Mouser, Marion, past-president.

OTTAWA

The Woman's Auxiliary to the Ottawa County Medical Society met at the home of Mrs. J. C. Witker, Lakeside, on June 10. Eight members were present. A business meeting at which the standing committee chairmen were named, was followed by a social hour with Ottawa County Medical Society members.

PICKAWAY

The country home of Dr. and Mrs. Lloyd Jonnes of Circleville was the scene for the social meeting of the Woman's Auxiliary to the Pickaway County Medical Society. Members gathered for an all-day outing.

SCIOTO

At an impressive ceremony in the banquet room of the Cameo, Mrs. George E. Obrist was in-

stalled as president of the Woman's Auxiliary to the Hempstead Academy of Medicine. The installation program was conducted by Mrs. William E. Gault. Mrs. Gault presented new officers with rose buds, symbolic of their hopes and plans. Along with Mrs. Obrist, Mrs. W. A. Ray was installed as president-elect, Mrs. Herbert Keil, vice-president, Mrs. Garnet Neff, secretary, and Mrs. C. L. Ferguson, treasurer. Mrs. Milton Levine is the retiring president.

TUSCARAWAS

Fourteen members were present for the June 15 meeting of the Woman's Auxiliary to the Tuscarawas County Medical Society which was held at the home of Mrs. Harold Wherley at Stone Creek. Following the regular business meeting, the group adjourned for the summer months.

Activities of the Editor

Recent activities engaged in by Dr. Jonathan Forman, Editor of *The Journal*, include the following:

On Wednesday evening, June 9, addressed the Upper Arlington Garden Club. His topic was "The Living Soil."

On June 16, was the guest speaker at the first Rural-Urban Dinner given by the Agriculture Committee of the Hamilton Chamber of Commerce. His subject was "Soil, Wealth, and Health."

Recently was the featured speaker on the Farm and Home Hour, the only program which all NBC stations and affiliates take, giving him 52,000,000 minutes of listeners' attention to tell the American people that health comes from a good diet and from an obedience of the laws of hygiene and not from any system of political medicine.

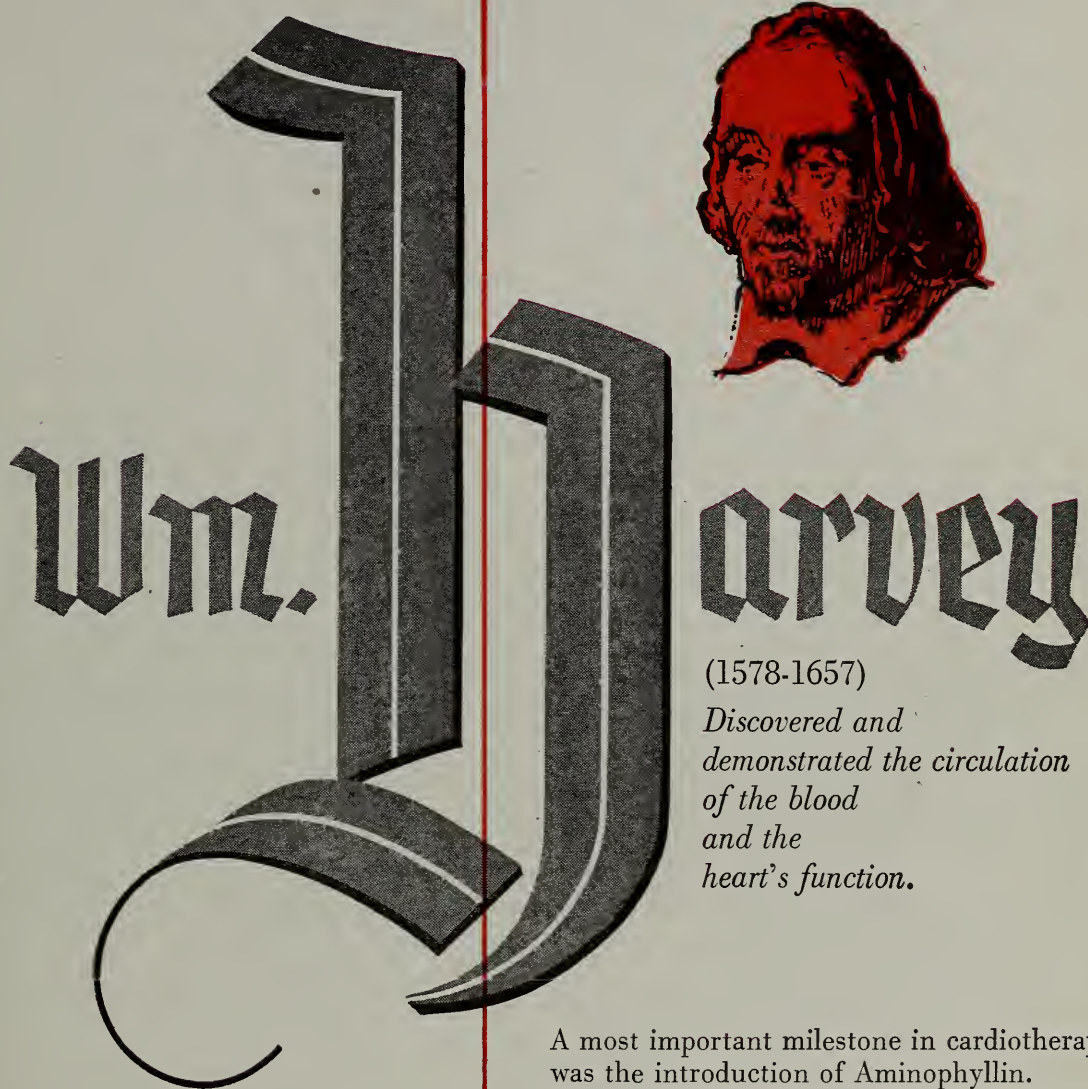
Acted as leader for a workshop on the use of the radio to educate the public in matters of health. This workshop had been arranged and to some degree promoted by Dr. Forman for the Eighteenth Annual Institute for Education by Radio, sponsored by the Ohio State University.

Appeared on Station WOSU in a feature program in conversation with Robert Crew, vice-president of the Ohio National Bank of Columbus, and treasurer of Friends of the Land, and O. R. Fink, executive secretary of the same society. Dr. Forman is vice-president of the organization and editor of its quarterly publication, *The Land Letter*.

Was elected treasurer of the American Association of Medical History at its recent annual meeting.

Addressed the Ohio Conference of the Christian-Congregational Church at the chapel of Heidelberg College, Tiffin. His subject was "Rural Living."

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Public Health Funds in Ohio . . .

Bulletin Issued To Local Health Commissioners Carries Breakdown On Money Supplied by Local Areas, State, and Federal Government in 1948

FIRST of a series of informational bulletins to local health commissioners regarding the current financial picture of public health activities in Ohio as estimated for July 1 has been issued by State Director of Health John D. Porterfield.

The bulletin sets forth some significant facts, namely:

During the calendar year 1948, local appropriating bodies have appropriated funds for local public health department activities which amount to only 62 cents per capita.

For the same period appropriations by the State of Ohio for operation of the State Department of Health amount to but 5 cents per capita and for subsidies to local health districts only 4 cents per capita, or a total of 9 cents per capita.

During 1948 the State Department of Health will receive from the Federal Government funds representing 14 cents per capita for central services and administration and 11 cents per capita for subsidies to local health districts, or a total of 25 cents per capita.

In 1948, the Federal Government will supply 73 per cent of the money used for central services and administration in the Ohio Department of Health and 14 per cent of the money used by local health departments for public health activities.

DETAILED DATA

Additional information on these points is given in the bulletin, reading in part as follows:

"On the basis of information provided this office from local areas, there has been appropriated for the calendar year 1948, a total of \$4,655,686.51 by local appropriating bodies for local boards of health. This is an approximate average expenditure of 62 cents per capita.

"During the calendar year 1948, State appropriations for public health amount to \$697,151.00. Of this, \$390,151.00 is designated for the Ohio Department of Health; \$307,000.00 is available for subsidies to local health districts. This provides approximately 5 cents per capita for the operation of the State Department and 4 cents per capita for subsidy of local public health activity. The latest available national survey of public health finances indicates for the country as a whole an average State appropriation for public health of 50.4 cents per capita.

FEDERAL FUNDS

"Final Federal grant-in-aid figures are not yet available, but present estimates indicate Ohio will receive approximately \$1,864,000.00 to be used as supplement for local and State appropriations.

"The current budget of this Department covers all of the centralized services provided to local areas, including such activities as: the mobile dental trailers (13,000 school children examined in 1947), the mobile X-ray units (125,600 X-rays taken in 1947), the Rapid Treatment Center (3,040 patients treated in 1947), the State laboratory services (16,000 diphtheria specimens examined; 14,000 tuberculosis specimens examined; 11,000 gonococcus specimens examined; 18,000 water samples examined; 250,000 serologic tests for syphilis done; 1,412 rabies specimens examined in 1947), provision of biologics (15,000 vials of diphtheria toxoid provided; 22,000 point packages of smallpox vaccine provided, 13,000 measles immune globulin vials provided, etc., in 1947), anti-venereal drugs furnished (2,000,000 units of penicillin; 36,000 grams of arsenicals; 70,000 grams of bismuth; 188,024 ampoules of silver nitrate in 1947), and other services, such as the provision of consultation in the fields of

PUBLIC HEALTH FUNDS IN OHIO—BY SOURCE OF FUND¹

Source	Central Services and Administration			Local Health Units		
	Amt.	Per Cap.	%	Amt.	Per Cap.	%
Local ²	\$	---	---	\$4,655,686.51	.62	81
State	390,151.00	.05	27	307,000.00	.04	5
Federal	1,050,774.25	.14	73	794,939.57 ³	.11	14
Total	\$1,440,925.25	.19	100	\$5,757,626.08	.77	100

(1) Local and State funds as appropriated for calendar year 1948. Federal grant-in-aid as estimated for for fiscal year beginning July 1, 1948.

(2) Excludes funds from voluntary sources devoted to public health in local areas.

(3) Allotted to 60 cooperating local health units.

environmental sanitation, industrial hygiene, health education and other fields. Such items as the above are recognizable as allotments to local units in terms of service rather than personnel or funds.

"These services, plus central administration, require a budget of \$1,440,925.00. It was necessary to budget \$1,050,774.00 of Federal grant-in-aid money to the Department to provide the difference between the State appropriation and the budget necessary to carry out the responsibilities imposed on the Department by State law and regulation. This means that the State Department is supported to the extent of 73 per cent of its annual budget by Federal funds. The remainder, \$794,939.00, has been set up in co-operative budgets with 60 full-time local health units."

Western Reserve Polio Center

The National Foundation for Infantile Paralysis has awarded Western Reserve University a five-year grant of approximately \$100,000 to set up a model polio training center for doctors, nurses and physical therapists. The center is at City Hospital, Cleveland, under direction of Dr. John A. Toomey.

Three 10-day courses for physicians and three courses of two weeks duration for nurses and physiotherapists were scheduled to start July 16, Aug. 3, and Sept. 13.

Southeastern General Practitioners Elect Dr. Fitch

Dr. Clyde M. Fitch was elected president of the Southeastern Chapter of the Ohio Academy of General Practice at an organization meeting in Jackson on June 17. Other officers elected were Dr. Herbert D. Chamberlain, McArthur, president-elect, and Dr. J. D. Swango, Waterloo, secretary-treasurer. Dr. Joseph Lindner of Cincinnati, president of the Ohio Academy, was special speaker.

Meiling Resigns As Secretary But Will Continue on A.M.A. Council

Dr. Richard L. Meiling, Columbus, member of the Committee on National Emergency Medical Service of the Ohio State Medical Association, has resigned as secretary of the Council on National Emergency Medical Service of the American Medical Association but will continue to serve as a member of the council. Dr. Meiling resigned as secretary of the A.M.A. council because he could not devote sufficient time to the job. His resignation was accepted by A.M.A. officials with regret and an expression of appreciation for the fine work he has done as secretary.

Reproduce Cumulative Index

Arrangements have been completed for the reproduction of out-of-stock copies of the Quarterly Cumulative Index Medicus from 1927 to 1946, inclusive. It will require several months to complete the job and when it is finished these sets covering the 19 years will be available for \$350 delivered. Single volumes also will be available at special prices. Inquiries and orders may be mailed to B. M. Bruce, Manager, Order Dept., A.M.A., 535 N. Dearborn St., Chicago 10.



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Cash Sickness Benefits . . .

Financial and Administrative Difficulties Encountered by Rhode Island Program Described by Actuary; Warnings on Eventual Costs Sounded

IN current moves to expand the coverage of the Social Security Program, the advocates have stressed the addition of disability benefits for those who are unable to work because of sickness. Three states, Rhode Island, California, and New Jersey, have amended their Social Security laws to include sickness benefits.

What about this business of cash sickness benefits? Will other states be under pressure to follow the example of Rhode Island, California, and New Jersey? Are such plans actuarially sound? What do, or will, they cost in tax dollars? What about administrative expenses? Is malingering a problem?

Most of these and other logical questions which might be asked are answered in an article, "Sickness Pays in Rhode Island," written for the *Christian Science Monitor* by Elizabeth W. Wilson, an actuary of importance, and republished recently in *Insurance Economics Surveys*, bulletin of the Insurance Economics Society of America.

Although the article by Miss Wilson is not an exhaustive review of the Rhode Island situation, and probably was not intended as such, it does raise some pertinent questions and throws out some real warnings regarding cash sickness benefit programs under political administration. The article as republished in *Insurance Economics Surveys* follows:

* * *

Malingering Poses Problem: Rhode Island has just finished its fifth year of a unique experiment. Ever since April 1, 1943, the workers there—about 300,000 of them—have been entitled to cash benefits ranging from \$6.75 to \$18 a week whenever they were sick at least two calendar weeks during the year. They get nothing for the first week but after that they are paid for periods varying from about four to twenty weeks, depending on their weekly benefit rate and wage credits. Workers who make \$1,800 or more may receive the maximum—\$18 for 20½ weeks.

From a national standpoint, the Rhode Island experiment is a good thing. It has shown that a state system is a costly luxury. Had Rhode Island workers paid an actuarial premium, almost three-fourths of them would have paid the present system more than they would have given private carriers for equally favorable coverage. It has proved, too, there is very real danger that such a scheme may become a political football. The issues involved are too important, too serious, to be playthings.

This insurance is an offshoot of the Unemployment Compensation System. After the Social Security Act was passed, the various states enacted employment security legislation. Some of them, including Rhode Island, provided that

both workers and employers contribute. The late '30's and early '40's was a period of increasing employment. The reserves mushroomed. Five of the nine states discontinued employee taxes.

For some inexplicable reason, the Rhode Island labor and political leaders objected to this. Gov. J. Howard McGrath consulted the Federal Social Security experts. The State Unemployment Compensation Board, with the counsel and assistance of Washington, drafted a bill for cash sickness benefits. Twenty legislative days after it was introduced the General Assembly passed it—an unheard-of speed for a measure of this importance. It became law April 23, 1942.

The lack of opposition to it was due primarily to the fact that it did not seem to cost anybody anything. The workers had been paying 1½ per cent of their wages for unemployment compensation. One per cent of this was to be diverted to finance the new scheme, so labor felt that it was getting more for its money. Industry said it was the workers' fund; it could not interfere. The doctors thought that since no medical benefits were involved, it was not their problem. How wrong they all were!

The great difficulty in administering health insurance is to prevent malingering. Claim adjusters have found that the nearer the total benefits approach the net wage, the greater is the problem of fraud. Originally, workers whose employers continued to pay their wages during disability and recipients of workmen's compensation benefits were debarred from receiving cash sickness payments. The law was amended to include these groups during May, 1943.

That meant, of course, that many workers made more for themselves when they were sick than when they worked. Sickness paid. For instance, a woman worker at one of the big plants made \$30 in wages; that is, she took home about \$27 a week. She strained her back while working. Her weekly benefits amounted to \$47, tax free and deduction exempt!

Notwithstanding these handicaps, the first benefit year ended with a \$1,000,000 surplus. Then came the crisis. In March, 1944, only about 4,500 benefit checks were issued a week.

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By June this number had risen to 8,700. The medical staff at the board had examined about half of the claimants in the early spring. In September, 90 per cent were summoned to appear. About a fourth of these failed to come, and a slightly larger proportion of those examined were denied benefits.

By the next spring, the situation was so critical that a special committee was appointed to investigate.

Powerful labor leaders were members, but nevertheless the recommendation was that the law be made less liberal, and that the total employee contribution (1½ per cent) be allocated in the cash sickness fund. The General Assembly acquiesced and passed the first legislation that was politically unpalatable. A few months later, Congress incorporated the Knowland Act into the Social Security law. It permitted any state in which the workers had contributed to unemployment compensation to divert the accumulated sum of employees' taxes into a cash sickness fund. That meant the Rhode Island reserve could get a windfall of \$28,000,000.

One would have supposed that this would have been set aside as a protection against epidemics, recessions, and catastrophies which as yet the fund has never had to weather. That was not the politicians' idea. The dwindling reserve from which payments had previously been made, was set aside as the fund for administrative expenses. The bonanza became the source of all benefit payments. The employees' contributions were reduced immediately. Limitations as to payment of benefits to retired workers, which had been enacted the previous year, were repealed. The administrative expense limit was set at 6 per cent, a sixfold increase in five years. This year legislation was proposed to almost double the benefits. The situation is not actuarily sound.

Ohicans on Chicago Faculty

Several Ohio physicians are on the faculty of the Chicago Medical Society's postgraduate courses in Hematology and Neurology, Sept. 13-18 and in Cardiovascular and Respiratory Diseases, Sept. 20-25.

Included on the faculty of the course in hematology and neurology are Dr. George Guest, Cincinnati; Dr. R. W. Heinle, Cleveland, and Dr. B. K. Wiseman, Columbus.

Among the cardiovascular and respiratory diseases faculty members are Dr. William H. Bunn, Youngstown, and Dr. Irvine H. Page, Cleveland.

An article headed "Cincinnati's War on Death" in the July issue of *Coronet* tells the story of the Cincinnati Public Health Federation since it was founded 31 years ago.

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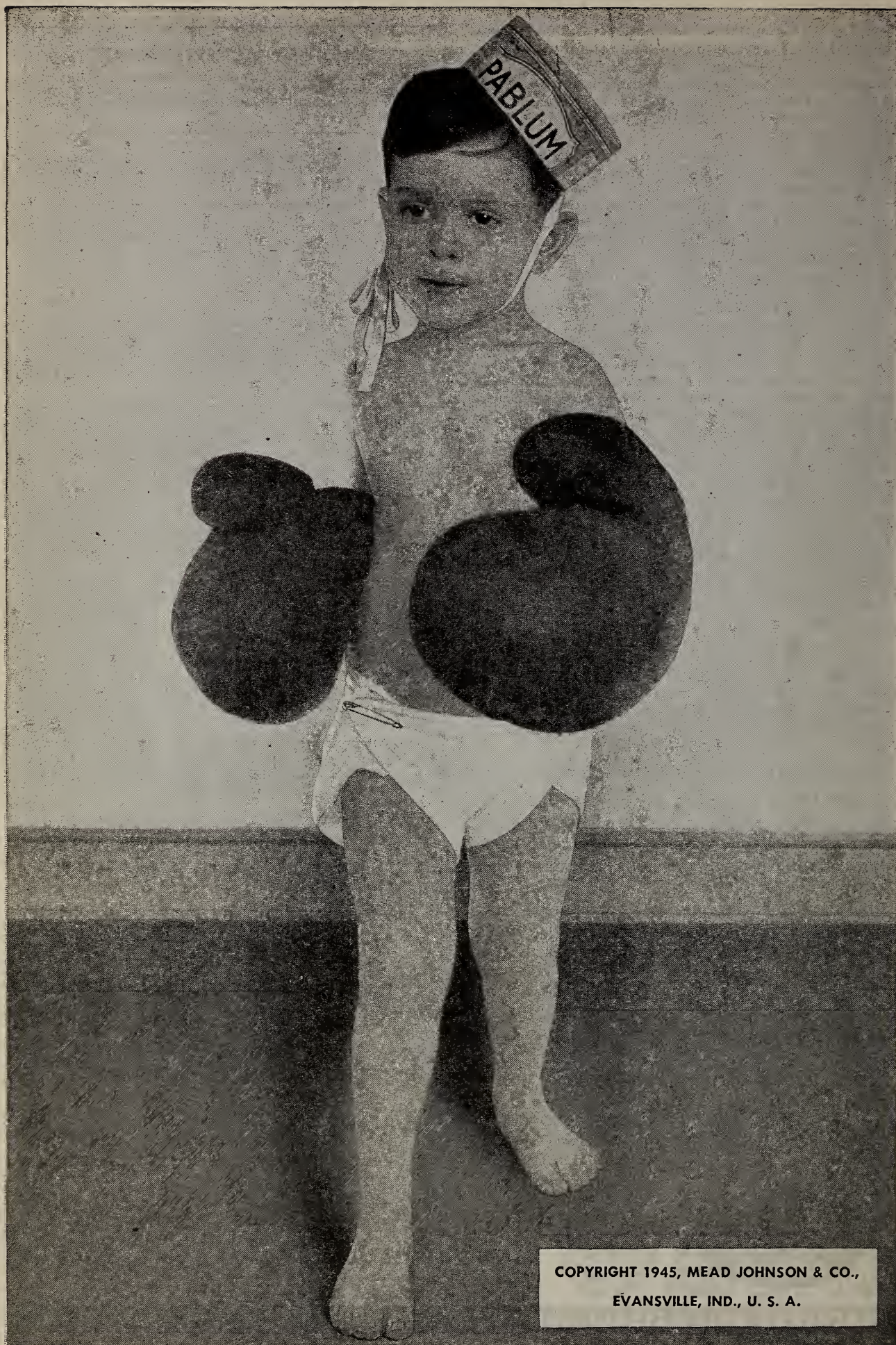
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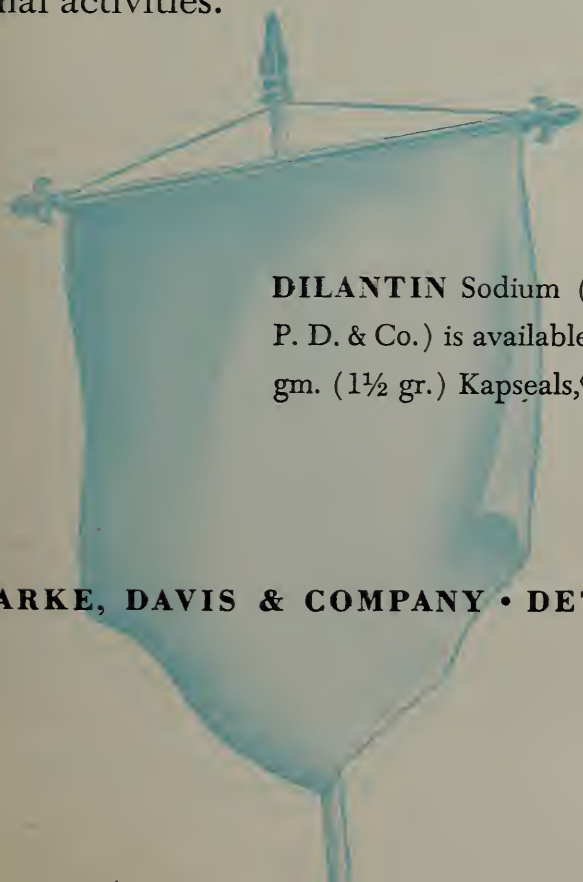


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The Physician's Bookshelf

By Jonathan Forman, M.D.

One Concept of the Present-Day General Practitioner

You and Your Doctor—A Frank Discussion of Group Medical Practice and Other Modern Trends in American Medicine, by Benjamin F. Miller, M.D., (\$2.75. *Whittlesey House, McGraw-Hill Book Company, New York City*) begins with the very sensible observation that adequate medical care can result only from the combined efforts of all the citizens; that the problems presented are comprehensible to every intelligent person. This volume then is an attempt to do just that in plain, non-technical language. The author correctly lists the major problems today as: (1) The future of the general physician; (2) the place of group practice; (3) an insurance plan for medical care; (4) the extension of preventive medicine. The reviewer is spending all of his spare time preaching that the first attack on the problem of adequate medical care is to cut it down to the size of our resources by instituting a sound nutrition program which would do away with almost all of the problem and give us a prosperous agriculture upon which to build national prosperity. As a corollary of this proposition your reviewer believes that our methods of care for the sick need complete re-evaluation. Too expensive and too prolonged professional educations, waste and inefficiency in hospital practice and management, the desire for ostentatious displays in architecture, and our present methods of discovery, testing, advertising, and marketing new remedies have all combined to give a service which is too expensive.

Of the general practitioner the author says he has become a casualty of modern science and it is for this reason that the entire system of medical practice is collapsing before our very eyes. He then proceeds to paint the picture of the general practitioner of a type quite unknown to your reviewer although he knows thousands of American general practitioners throughout the United States. This physician arises at 6 a. m., gets to the hospital before 8, does two tonsillectomies, a hernia, a gallbladder, and a thyroidectomy while keeping a woman in labor waiting. After his operations which are finished before noon (!) he hurries to the woman in the suburbs, sends her in, and rushes to see an old man with a chest pain. He needs an EKG. If he could have afforded a portable machine (five operations in the morning would easily have paid for it—Reviewer) he wouldn't have had time to learn to interpret the readings. So

he sends a laboratory technician (who is the person to do the job anyway). This is pictured as a great strain on the patient's modest pension. (In any town it would not cost any more than the physician's visit and less than in any hospital.) His next emergency turns out to be a case of measles. He snatches a lunch at the corner drug store which no human being should ever eat and which of course is steadily lowering his efficiency but of this our author says nothing. We follow our Doctor through a long afternoon of routine office calls, then house calls, and back to the office for evening office hours (four nights a week).

In the office he runs into what appears to be an advanced case of cancer of the intestine which the author thinks should be sent to a distant city specialist; but the patient cannot afford it, and anyway, has more confidence in his own doctor. So the doctor schedules him. It is the same dreary picture that has always confronted the successful physician who never has been able to arrange his affairs and who has never learned to say "no." In your reviewer's opinion, this is the fault of our fantastic medical curriculum and hospital routine in our intern days. It is overdrawn as your reviewer knows medical practice. It is an excellent picture of what the average full-time professor of medicine thinks general practice would be like.

To bolster the case, however, the author then parades a rather formidable list of mistakes such as come to a university clinic. Any group of general practitioners could recite as equally a long list of mistakes made by the most competent university specialist. Medicine is not a science and there will always be a small but definite percentage of mistakes by its best practitioners. The author says that everyone has given serious consideration to the discrepancy between the medical service we require and the medical service we get. This is the social point of view of one who knows so much about so little. If the people of Columbus at the turn of the century had listened to their leading medical men, they would have solved their typhoid problem just as this author recommends, by providing more nurses and specialists at a price the people could afford. But they did better, they ignored what their medical men said and listened to a bacteriologist and the engineers. They got a pure water supply and we have had "adequate

care" for typhoid fever ever since and at no expense to any one.

The author, however, proposed instead to reorganize the 120,000 general practitioners. His solution would be to insert what he calls "a pilot physician" into the scheme of things. This one would do just what some 40 men are doing in Columbus right now. In an office equipped with a competent laboratory and an adequate X-ray machine, he goes carefully over the patient for the family physician, returns those who should go back to the family physician supervising the treatment of some, and is especially qualified to refer his patient to proper specialist for problems outside his field.

Then follows the glorification of group practice and salary plan with nothing said about the "overcharge" of this producer-type of cooperative or "profits" for those privately owned or held in trust.

But enough, every physician who wants to know where Medicine is going as we stand half-way through the era of State Capitalism and proceed farther into State Socialism, instead of looking back at the good old days prior to 1945 when we lived in the free enterprise, should read this book to see where our educators are taking us. My greatest regret is that we shall never live to see the prophecy of J. A. Schumpeter completed:

"If capitalism repeats its past performance for another half century starting with 1928, this would do away with anything that according to present standards could be called poverty, even in the lowest strata of the population, pathological cases alone excepted." (from J. A. Schumpeter's "Capitalism, Socialism, and Democracy.")

* * *

Barbed Wire Surgeon, by Alfred A. Weinstein, (\$3.00. *Macmillan Company, New York City*) is the story of forty months in Japanese prison camps.

Diseases of the Nose, Throat, and Ear, by I. Simson Hall, (\$4.50. Fourth Edition. *Williams and Wilkins, Baltimore*) is a handbook for students and practitioners brought up to date with exposition of the impact of penicillin upon the specialty and the Fenestration Operation forces in proper perspective.

Out of This World, by Sylvan Shane, M. D., (\$2.00. *Creative Age Press, Inc., New York City*) is the story of anesthetics and what they do to you, by the anesthesiologist of the South Baltimore General Hospital.

Woman's Inside Story, by Mario A. Castallo, M. D., and Cecilia L. Schultz, R. N. (\$3.00. *Macmillan Company, New York City*) is a very

persuasive book on the maintenance of good health through proper care of the reproduction organs.

Your Carriage, Madam! by Janet Lane, (\$2.50. Second Edition, *John Wiley and Sons, Inc., Philadelphia*) tells the story of posture in relation to female carriage, health, style, and poise as it did in the first edition twelve years ago. In this edition, however, the author has modernized and amplified the text to increase its attractiveness and, therefore, its power to motivate.

Bodies and Souls, by Maxence Van der Meersch, translated from the French by Buthwe W. Wilkins (\$3.75. *Pellegrini and Cudahy, Inc., New York City*) with its medical students, professors, and their families, belongs in the libraries of physicians.

How To Keep Happily Married, by Joseph L. Fox, (\$2.50. *Dorrance and Company, Philadelphia*) is a well-done text in the popular vein emphasizing in the current fashion ignorance of sex as the basis of much marital discord.

Physiology of Exercise, by Laurence El Morehouse, and A. T. Miller, (\$4.75. *C. V. Mosby Company, St. Louis*) is a text based upon the researches of "The Fatigue Laboratory" and should be digested thoroughly by every physician.

British Surgical Practice, under the general editorship of Sir Ernest Rock Carling and J. Paterson Ross, (\$15.00. Volume II. *C. V. Mosby Company, St. Louis*). This volume deals with "B's from Backache to Bursae. The work is encyclopedic but concise—done in the best tradition of British medical writing.

The 1947 Year Book of Endocrinology, Metabolism, and Nutrition, edited by Willard O. Thompson, M. D., and Tom D. Spies, M. D., (\$3.75. *Year Book Publishers, Inc., Chicago*) again gives a convenient and adequate summary of the literature in these important fields. As Spies says in his introduction, "Gradually it has become apparent that the function of folic acids, amino-acids, vitamins, and minerals is much more obscure than once supposed. Every function of every cell is dependent upon them." Old people need them as badly as do infants. "Life is never static."

Psychiatry, Its Evolution and Present Status, by William C. Menninger, M. D., (\$2.00. *Cornell University Press, Ithaca, New York*) consists of the three Menninger Lectures for 1947. It presents an intelligible discussion of the mechanisms involved in man's struggle with emotional conflicts. This he ties into the story of the growth and development of psychiatry. He then discusses the factors of resistance against stress and describes what happens when this collapses or is overwhelmed. Finally, Dr. Men-

ninger applies what he has learned from individual analysis to the diagnosis and treatment of Society's ills.

Arterial Hypertension, by David Ayman, M. D., (\$2.50. Reprint from Oxford Loose Leaf System. *Oxford University Press, New York City*) is a small volume of 86 pages. In it these diseases are classified as cases without renal disease, cases associated with primary renal disease, and cases due to hormone production of certain tumors and to various intoxicants. Dr. Ayman makes a critical analysis of restricted diets, potassium thiocyanate properly checked with blood level determinations, sympathectomy—especially valuable is the discussion of the indications and the limitations of this last procedure. After reading this critical study one comes to realize that Medicine as an applied science today, is helpless before this well-known, easily recognizable but baffling disease. It appears to your reviewer that a considerable sum of money could be deducted from the total cost of medical care if we were to tell these patients the truth—that nothing known today and no one—unless it is their pastor—is going to help them. The repeated application of this test and that test, the use of one instrument after another only increases the total cost of medical care to the patient, and only increases the sum total now spent for medical care which is all out of proportion to the sum total of the net individual income of our citizens. Again the machine has out run our civilization.

Subacute Bacterial Endocarditis, by Emanuel Libman, M.D., and Charles K. Friedberg, M.D., (\$3.50. An Oxford Medical Publication—A Reprint. *Oxford University Press, New York City*) deals with one of the diseases which recently, through the introduction of antibiotic and "sulpha" drugs, has changed very considerably in its clinical aspects. This text has been revised by the junior author. The physician who reads this little volume carefully and individualizes for his patient what he has learned will not only treat his patient intelligently but effectively.

The Skull, Sinuses and Mastoids—A Handbook of Roentgen Diagnosis, by Barton R. Young, M. D., (\$6.50. *Year Book Publishers Inc., Chicago*) presents the findings of the normal at all stages of development from birth to adult life, and all variants, anomalies, and diseases.

Diagnosis in Gynaecology, A Classification of Gynaecological Diseases Based on Aetiology and the Clinical Logic for Diagnosis, by James V. Ricci, M. D., (\$4.50. *The Blakiston Company, Philadelphia*) follows no accepted classification but here the genital structures and the various diseases which affect them form the basis of presentation. Certainly this book offers many

helpful suggestions to the teacher and may be of service to medical students. It is also intended to help practitioners as they approach diagnostic problems in this field.

Practical Bacteriology, Hematology and Parasitology, by E. R. Stitt, M. D., Paul Clough, M. D., and Sara E. Branham, M. D., (\$10.00. Tenth Edition. *The Blakiston Company, Philadelphia*) has grown from the little pocket manual that I knew in 1910 to a volume of over 1,000 pages. Many contributors have joined in producing the book in its present complete form. When your reviewer first met the senior author in the Harvard Summer School back in 1912, he was industriously assembling data that could be applied to the laboratory in helping diagnose sickness aboard ship or on some isolated island. This he has never stopped doing and so his book has always been concise, complete, and all that one ever needed to do the day's work.

Nutrition and National Health, being the Cantor Lectures before the Royal Society of Arts, 1936, (*Faber and Faber, Ltd., 24 Russell Square, London, England*) is a reprint of these epoch-making lectures. Their thesis is that the greatest single factor in the acquisition and maintenance of good health is perfectly constituted food. This truth is now generally accepted. The League of Nations bore witness to it. The United Nations has set its seal of approval upon it. Friends of the Land have repeated it to millions of American readers and listeners in auditoriums and over the air. The lesson American should learn from it is this: It will do no good to set up a more adequate system of medical care of preventive medicine until it promotes a degree of prosperity that will permit a prosperous agriculture to produce the food that is necessary to maintain the health of all of our people. This can be done but in the last twenty years we have travelled far in the opposite direction.

Venous Thrombosis and Pulmonary Embolism, by Harold Neuhof, M. D., (\$4.50. *Grune and Stratton, New York City*) has been written because present-day interest and investigation has brought out many conflicting views. This monograph sets forth the importance of the study and treatment of these conditions by a hospital team selected for that purpose by setting forth what one such team (Mt. Sinai, New York) has done and the correlation of their experiences with the literature.

The Care and Feeding of Parents, by William Hall, (\$2.00. *Thomas Y. Crowell Company New York City*) is designated as an obstructed view of childhood from birth to kindergarten. It carries the information through in chronological order from "Greetings" to "Don't jump up and down on her lap. She's pregnant again."

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A Case of Mercuric Chloride Poisoning Treated with British Anti-Lewisite (BAL)

JEROME S. FRANKEL, M.D., SEABURT GOODMAN, M.D., and SAMUEL HANTMAN, M.D.

THE treatment of mercuric chloride poisoning has been very unsatisfactory in the past. The numerous methods used demonstrate the inadequacy of any satisfactory therapeutic measure. The treatments at various times included: (1) cecostomy, (2) peritoneal irrigations, (3) sodium thiosulfate intravenously, and (4) sodium formaldehyde sulfoxylate intravenously, by lavage and by irrigation. Berger, Applebaum, and Young¹ showed that patients with mercury poisoning coming to autopsy were found to fall into three groups: "Group 1. Those dying within forty-eight hours of the ingestion of the poison in shock, following an extensive and severe gastritis, with marked hemorrhagic necrosis of the stomach wall. Group 2. Those dying from forty-eight hours to seven days after the ingestion with retention of nitrogenous substances following a severe necrotizing nephrosis. Group 3. Those dying from seven to twelve days after ingestion with an extensive and severe gangrenous colitis, the kidney lesion at this time showing evidence of healing." Patients ingesting lethal doses of mercury and found in shock did not respond to the usual measures for shock treatment. The renal complications were not amenable to treatment until the introduction of peritoneal irrigations. The gastro-intestinal complications could, in part, be treated and prevented by prompt lavage with sodium formaldehyde sulfoxylate and early cecostomy. Sodium formaldehyde sulfoxylate

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late acted by reducing corrosive mercuric chloride to insoluble and less toxic mercurous salts or to metallic mercury.²

"BAL"

In 1939, as part of a program of War Research at Oxford University, a compound 2, 3-Dimercaptopropanol (British Anti-Lewisite, "BAL") was developed by Peters, Stocken, and Thompson³ for the treatment of arsenic poisoning. The toxicity of arsenicals was known to rest on the fact that they combined with and blocked the function

of the oxidase enzyme system of the cell. This system depended on the -SH groups which in the presence of trivalent arsenic was rendered inactive because of the combination of the arsenic with the -SH groups. This stable combination of arsenic with tissue proteins was reversible to a minor degree in the presence of monothiols such as cysteine or glutathione. Synthetic dithiol compounds such as 2, 3-Dimercaptopropanol were far more effective in competing for arsenic than the dithiol containing protein in the tissue. The enzyme inhibitions could be reversed by the use of 2, 3-Dimercaptopropanol if the reaction with arsenic was not too long established. Other heavy metals including mercury,^{4a, 4b} lead, antimony, bismuth, cadmium, and zinc also produced inhibitions of the oxidase enzyme systems.⁵ The application of 2, 3-Dimercaptopropanol (British Anti-Lewisite, "BAL") in the treatment of poisoning with mercury,^{4a, 4b} gold,^{6a, 6b, 6c} and zinc and cadmium⁷ have been reported recently.

In case of mercury it has been shown experimentally that in vitro, one mol of BAL reacted with one mol of mercury to form an insoluble easily dissociated compound. The addition of another mol of BAL formed a soluble compound of extremely low-dissociability. It was probable that the efficiency of BAL was due to the rapid formation and excretion of this relatively undissociated soluble compound.

46 CASES IN 7 YEARS

A review of forty-six cases of mercuric chloride poisoning treated at the Mount Sinai Hospital of Cleveland, Ohio, from 1937 to 1944 showed the following: The smallest amount of mercury bichloride ingested was 0.5 grams, and the largest amount was 4.5 grams. The smallest amount producing death was 1.0 grams, the largest amount was 4.5 grams. No case survived following the ingestion of more than 2 grams. There were many cases giving a history of ingestion of large amounts of mercury bichloride which failed to show mercury in either the gastric washings, colonic irrigations, or the urine. The reason for this may be that either the stated amount ingested was actually never taken, or that the tests available were not sensitive enough to show mercury in the excreta.

The treatment during this period varied. Prior to 1940, there were ten cases treated with sodium thiosulfate. One case was treated with sodium thiosulfate and cecostomy. In this group there was one death, in a patient ingesting 1.5 to 2.0 grams of mercuric chloride. After 1940, 34 cases were treated with sodium formaldehyde sulfoxylate. In this group seven expired. Two cases were treated with sodium formaldehyde sulfoxylate and cecostomy, and one of these died.

Gilman, Allen, Phillips^{4a} and Longscope and Luethscher^{4b} used BAL in the treatment of mercury poisoning with good results. We wish to

report a case of mercury bichloride poisoning treated with BAL, which would have fallen into Group 2 and 3 of Berger, Applebaum, and Young.¹ In our opinion, this case would not have survived with any of the previous methods of therapy.

CASE REPORT

A 48-year-old white male was brought to the hospital by the police approximately one hour after the ingestion of 8.5 to 9.0 grams of mercury bichloride. Following the ingestion of the mercury bichloride, the patient drank a small amount of lysol and tincture of iodine. No history of vomiting prior to admission was obtained, but in the emergency room, the patient had one emesis, containing a small amount of bluish colored material.

On admission, the patient was observed to be acutely ill, semi-comatose, and responding only to painful stimuli. A first and second degree burn on the left side of the face and neck was noted. The mucous membrane of the mouth appeared intact. The blood pressure was 230/130, the heart rate was regular and rhythmic and 120 per minute. No cardiac murmurs were heard. The liver was palpable two fingers breadths below the right costal margin.

In the emergency room, the patient's stomach was lavaged with a five per cent solution of sodium formaldehyde sulfoxylate, using about 300 cc. of the solution. Following this, about 500 cc. of milk was placed into the stomach through a Levine tube as an antidote for the lysol and iodine. The first stomach washings contained material which grossly appeared to be gastric mucosa. The washings were blue and gave a strongly positive test for both mercury and lysol, and a negative test for iodine. The pathological microscopic report of these gastric washings was: "Degenerative mucous cells and amorphous pink-stained material."

Four hundred and fifty mgms. of BAL-in-oil was given by intramuscular injection. This was larger than the recommended initial dose of BAL of 5 mgm. per kg. of body weight, which in this patient would have been about 350 mgms. It was felt that this larger dose was indicated because of the massive dose of mercury bichloride ingested.

The patient was placed on the recommended dosage of 3 mgm. per kg. of body weight every four hours for the first two days. A similar amount of BAL was given four times daily for the third day and the same dose continued for the next ten days.

Intravenous fluids consisting of five per cent glucose in water was started and in the first twenty-four hours this amounted to 2000 cc. The total urinary output during this period was 50 cc. of grossly bloody urine, giving a strongly positive test for mercury. In the next twenty-four hours with a total intake of 2600 cc, the patient voided only 450 cc. of grossly bloody urine, showing two plus albumin and over 50 white blood cells per high powered field. Forty-eight hours after admission, there developed a severe bloody diarrhea which gave a strongly positive test for mercury. At this time one colonic irrigation with a 1:1000 solution of sodium formaldehyde sulfoxylate was given. The bloody diarrhea persisted for three days.

The patient was very restless and required constant sedation. On the third hospital day, he was able to take fluids by mouth and was placed on a

liquid diet. Improvement continued with increasing urinary output. Examination of the urine on the fourth hospital day showed the absence of albumin and only an occasional red blood cell and white blood cell per high powered field. The specific gravity of the urine was 1019. The urine, however, continued to show positive tests for

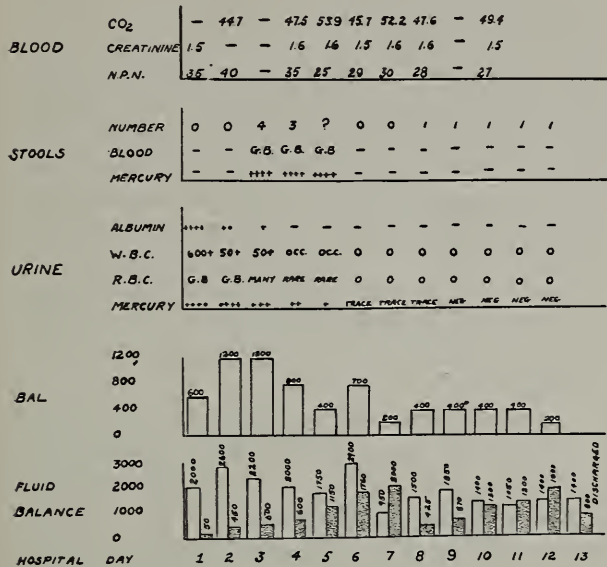


TABLE I: Detailed Summary Laboratory Findings: CO₂—Carbon dioxide combining power of the plasma; N.P.N.—Non protein nitrogen; G.B.—Grossly bloody; Plain Bar—Fluid intake; Spotted Bar—Urinary output.

mercury until the eighth hospital day. (See Table I for detailed summary of the laboratory findings.)

On the day of admission, the non-protein nitrogen of the blood was 35 mgm. per cent, the creatinine was 1.5 mgm. per cent, the blood chlorides was 609 mgm. per cent, and the blood sugar was 83 mgm. per cent. On the second hospital day, the non-protein nitrogen was 40 mgm. per cent and the carbon dioxide combining power of the plasma was 44.7 volumes per cent. The non-protein nitrogen never rose above 40 mgm. per cent, and the carbon dioxide combining power never was below 44 volumes per cent.

The patient was very lethargic for the first twenty-four hours, and then became very restless and irritable. By the third hospital day, he was entirely rational, and taking fluids by mouth. The blood pressure was maintained about 200 systolic and 130 diastolic for the first two days after admission. By the third day, the blood pressure was 140/100 and persisted at this lower level until discharge. The burn of the face and neck was almost entirely cleared by the fourth hospital day. There was no evidence of a stomatitis during the entire hospital stay. The patient was ambulatory by the fourth day and able to take a regular house diet on the fifth hospital day.

The reported toxic symptoms due to BAL^s such as nausea, vomiting and headache, burning sensation of lips, mouth, throat and eyes, pain in the teeth, generalized muscular aches, and burning and tingling of the extremities were not prominent features in our case. Except for a local burning pain at the site of injection, lasting for about ten minutes, nausea for a period of thirty minutes, the reactions were never serious enough to interfere with the outlined therapy.

In this hospital prior to the use of BAL, no case of mercury poisoning survived after the ingestion of more than two grams of mercury bichloride. In our opinion, the rapid recovery with a relatively mild hospital course would not have been possible in this case without the use of BAL.*

SUMMARY

- 1. A case of poisoning with 8.5 to 9.0 grams of mercuric chloride is reported.
- 2. The treatment consisted of the intramuscular administration of 2, 3-Dimercaptopropanol (BAL).
- 3. The total dose of BAL was 6900 mgm.
- 4. The patient was discharged as recovered on the 13th day after admission.

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*After the above case report was written, the same patient was again brought into the emergency room after the ingestion of 1.5 grams of mercuric chloride. The patient vomited immediately after ingestion of the poison, and arrived in the emergency room one and a half hours later. The patient was started on BAL and was given a total dose of 4550 mgm. The gastric washings showed a trace of mercury, and one specimen of urine showed a trace of mercury. The stool was slightly positive for mercury on the seventh hospital day.

The admission of the patient at this time gave us the opportunity to study this man's kidney and liver function. The non-protein nitrogen and blood urea nitrogen were within normal limits. The urine was concentrated to a specific gravity of 1030. The phenolsulfonphthalein (P.S.P.) dye test for kidney function was 75 per cent in one hour. The urea clearance test showed a standard clearance of 81 per cent of average normal function. The bromsulphalein test showed no dye retained at the end of 45 minutes (5 mgm. per kg. of body weight used). The intravenous hippuric test showed an excretion of 0.78 grams in one hour.

It is quite obvious that this patient has no kidney or liver damage as tested by the above function tests. This, in spite of large amount of mercuric chloride ingested during his first admission, and a smaller amount ingested during his second admission may be attributed to the treatment with BAL.

Papanicolaou Test in the Early Diagnosis of Uterine Cancer

C. E. HUFFORD, M. D., and EDWARD L. BURNS, M. D.

THERE are a number of methods available for making an early diagnosis of uterine cancer.

The patient's symptoms, the physical findings, biopsy and more recently the vaginal smear are all valuable aids. It should be emphasized that no single one of these methods is self-sufficient, but that each is extremely important if early cancer is to be recognized. By evaluation of symptoms, by performing regular physical examinations, and by taking biopsies, many early cancers of the uterus have been diagnosed and cured. In spite of efficient use of these methods, however, advanced lesions of the cervix and fundus of the uterus develop.

The vaginal smear is becoming more and more useful in making possible the early diagnosis of uterine cancer. The credit for the application of the vaginal smear method to human beings belongs largely to Papanicolaou who very early began to study the changes in the human genital tract. While they are not as marked or obvious as they are in animals, it has been found that definite changes do occur. Moreover, it has been found that neoplastic cells desquamate into the vaginal canal and may be recognized in smears. It is this property which makes the method useful for early diagnosis of carcinoma.

THE METHOD

The method of taking vaginal smears has been described by Papanicolaou.

A slightly curved glass pipette, six inches in length, 0.5 cm. in diameter, with a rounded tip and a small opening is attached to a strong rubber bulb for producing suction. The patient is placed upon an examining table in the lithotomy position. The rubber bulb is compressed before the glass tube is inserted into the vagina. The labia are then separated and the glass pipette is introduced into the posterior fornix of the vagina. The pressure on the bulb is then slightly released and the suction produced serves to aspirate vaginal fluid with its cellular content into the glass tube. While aspiration is in progress, the tip of the tube is moved from one side of the fornix to the other so that all parts are sampled. The pipette is then withdrawn, and the vaginal material is spread upon the surface of a clean microscopic slide with a sudden expulsive pressure on the bulb. Further spreading with the convex side of the pipette is advisable when the amount of fluid is abundant, as in cases where there is considerable bleeding or abundant mucus. Very thick smears are not well penetrated by the fixing fluids and cannot be uniformly stained.

The Authors

Repeated requests received by the Committee on Cancer of the Ohio State Medical Association for information regarding the practical application of the Papanicolaou test in the early detection of uterine cancer have stimulated the preparation and publication of the accompanying article which is based primarily on a report of the vaginal smear program inaugurated in November, 1947, by the Cancer Committee of the Toledo Academy of Medicine.

● Dr. Hufford is the chairman of the Committee on Cancer of the Ohio State Medical Association and director of radiology, St. Vincent's Hospital, Toledo.

● Dr. Burns, clinical pathologist at Mercy Hospital, Toledo, who has made special studies in the use of the Papanicolaou test, was a prime mover in setting up the Toledo program and has taken a prominent role in its operation.

The slides are immediately plunged into a solution of equal parts of 95 per cent alcohol and ether. Drying of the smears before fixation should be carefully avoided as it results in the loss of the sharp outlines of the cells and changes their staining reaction. The fixation does not require more than a few minutes, but smears may be kept in the alcohol-ether solution for four or five days.

PRECAUTIONS

A few precautions should be observed in the procurement of material for the vaginal smear. The vaginal contents should not have been disturbed by any form of examination or treatment. Douching or bathing, will, of course, dilute or completely wash away the cellular deposits for a period of several hours. If there is a considerable amount of fluid of either serous or sanguineous character, dilution will occur, in which case it is wise to make several smears to obtain the representative cell constituents which are ordinarily seen in a single smear.

Believing that the method was worth while, the Academy of Medicine of Toledo and Lucas County initiated a program which incorporated the use of the vaginal smear into a plan for making early diagnoses of uterine cancer. Certain preparatory steps were necessary before such a

program could be initiated. First of all it was necessary to educate the pathologists in the methods of evaluating the smears. This was done through study of the literature, experience in comparing vaginal smears with biopsies on patients whose uteri were removed for other purposes, compilation and circulation among the pathologists of study sets of slides showing smears and biopsies together, and by group meetings in which the findings and difficulties were discussed. The necessity for evaluation of the smears by experienced persons cannot be over-emphasized. Accurate interpretation of the smears is difficult and the number of mistakes made by untrained personnel will be sufficient to cause the program to fail.

Secondly, technicians were trained in the vaginal smear method; they are indispensable in carrying out such a plan. Two technicians from Toledo were sent to Cornell University to study with Papanicolaou. Here they learned the technique of staining, as well as reading the smears. It may be said at this point that technicians may become very proficient in examining smears, and while the diagnosis of abnormal smears should never be placed in the hands of technicians alone, it is possible for them to become efficient in screening the normal cases, and to present to the pathologist only the abnormal smears for his evaluation. It may be also stated that experienced technicians become very proficient in the evaluation of the abnormal smear. They are indispensable in the carrying out of any large scale program because they make possible the survey of a large amount of material.

Thirdly, it was necessary for the practicing doctors to be informed about the program. They were told about its purposes and limitations, particularly emphasizing that the vaginal smear is only a screening procedure. It was pointed out from the start that where physical examination suggested that biopsies should be made, this procedure should be carried out regardless of

what the smear showed. In this way errors in the smear diagnosis would not permit a recognizable uterine carcinoma to advance to a late stage. The doctors were also instructed in the methods of taking the smear, and it was emphasized that a complete pelvic examination should be done at the same time the smear was made.

EDUCATION NEEDED

Finally, it was necessary to educate the women as to the value of the program. This was done through talks to various organizations of women. We have found the women enthusiastic and cooperative, and anxious for some means of assuring themselves that they may not develop late cancer of the uterus. The problem in this respect has been one of restraint rather than promotion of the rate of growth so that the personnel can be trained to keep pace with the volume of the work. This gradual growth of the program is likewise an important part of the plan because no laboratory can possibly obtain over night sufficiently trained personnel to carry on a large scale examination of slides. However, through a process of gradual growth and concurrent training of technicians, it will eventually be possible to carry out the procedure on many women.

With the ground work laid in this fashion it became possible for the Academy to initiate a program. For the success of the program, it was thought that continuity of examination was the key to early recognition. Consequently it was proposed that women be examined regularly at six-month intervals. Enrollment of clinically well women was encouraged, the lower age limit being set at about thirty years.

In order to maintain this type of continuity it was necessary to set up a registry of the patients examined. This function was assumed by the Academy which organized and maintains the registry. The method of operation of this registry may be of some interest. The doctors are supplied with request slips (Figure 1) which

REQUEST FOR VAGINAL AND CERVICAL SMEAR FOR DIAGNOSIS OF CARCINOMA

Name.....	Age.....	Doctor.....	Date.....
Address			
Marital Status	S M W D	Children (state age).....	
Chief Complaints			
Menstrual History—Onset.....	Duration of period.....	L.M.P.....	
Interval between periods.....	Regular.....	Irregular.....	
Metrorrhagia.....	Spotting.....	Menorrhagia.....	Amenorrhea.....
Operations (especially pelvic).....		X-ray Treatment.....	
		Endocrine Treatment.....	
Pelvic Examination.....		Provisional Clinical Diagnosis.....	

Pathologist's Report

Do Not Write Below This Line

Figure 1

are put together in triplicate with carbon paper between each sheet of paper. The third sheet is a card. When the doctor makes a vaginal smear he fills out this request form which gives the patient's name and address, and pertinent clinical data. This is sent to the laboratory along with the smear. After the smear is examined the report is written at the bottom of the request slip and the three copies are distributed, one to the doctor, one to the pathologist, and one, the card, to the Academy of Medicine Registry. The Academy Registry files the card in such a

mending treatment or referring her to whomever he may think advisable. A report also goes to the registry where it is filed and at the proper time a notification of the date of the next smear is sent not to the patient herself, but to her doctor who in turn notifies the patient.

There are a number of points which we consider important in connection with this system of operation. First of all we believe that it is a good index to what can be accomplished by such a plan because it has originated in a community of practicing doctors outside of a medical center.

Your patient _____ is due to report to you for a routine vaginal smear on _____. Please fill out the inclosed notification card and send it to the patient in the inclosed addressed envelope.

To date, the vaginal smear has aided in making the diagnosis in _____ cases of uterine cancer at an early enough date so that complete cure is very probable. Prompt mailing of the inclosed card will add to the possibility of making additional early diagnoses.

ACADEMY OF MEDICINE
Toledo and Lucas County
1420 Monroe Street

Figure 2

Your appointment for another pelvic examination, including the Papanicolaou Test, is scheduled for _____ at _____ A. M. P. M.
If this is inconvenient, please call my office at once.

These regular examinations are the best means I know of for detecting early uterine cancer and other serious pelvic disorders. Please keep your appointment.

Please refrain from douching or bathing on the day of the examination as this interferes with the test.

M. D.

Figure 3

manner that at the end of the six months' period the doctor will receive notification that his patient is due to report for another smear. The doctor in turn notifies the patient of this request. Copies of these request forms are shown in Figures 2 and 3.

The operation of the program may be summarized as follows (Figure 4): The patient comes to her doctor, the smear and a pelvic examination are made. The smear is sent to the pathologist who makes a report which goes to the doctor. The doctor, in turn, contacts the patient recom-

The method of smear interpretation has been learned by a group of practicing pathologists who have had no unusual opportunity for research with the method or for special guidance. Consequently the results of such a program could be expected to be duplicated in any community of practicing doctors who desire to initiate it.

The routine for carrying on the program has been worked out and agreed upon by both the Academy of Medicine and the practicing doctors. This is of great importance because it is neces-

sary to operate a system which does not infringe upon the prerogatives of the practicing physician. It will be noticed that in this plan the doctor-patient relationship has been carefully preserved, that in every instance contact with the patient is made through her own private physician without interference by the Academy or any other organization. Some measure of the degree of acceptance of the plan can be obtained from the fact that 213 doctors of Toledo and the surrounding territory have participated in the program thus far.

Furthermore, the plan is essentially self-supporting from fees that are charged for mak-

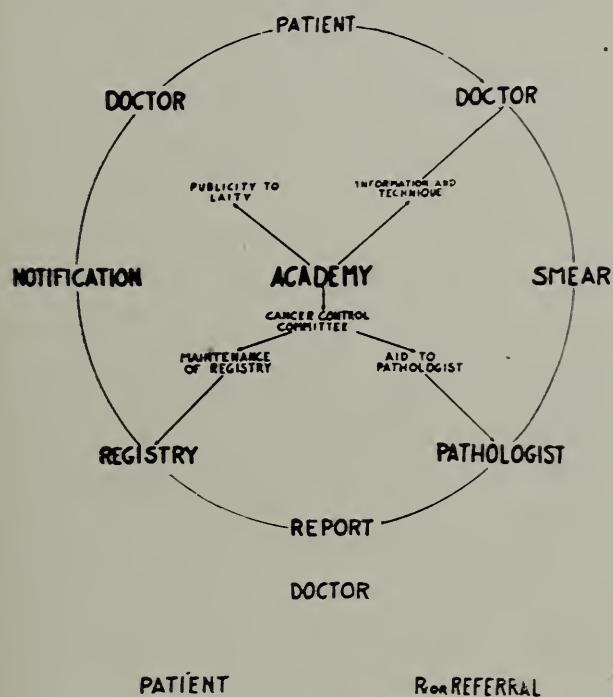


Figure 4

ing the smears. All of the laboratories in Toledo have agreed to examine smears on indigent patients without charge. Thus the plan may be carried to all levels of society.

THE RESULTS

The program has now been in operation for somewhat less than a year, and it may be of interest to observe the results. In evaluating these results we wish to emphasize that the plan at present is merely in the process of developing and that its final success is by no means assured. This depends upon continued work and upon continued enthusiasm and cooperation of all the individuals who participate.

Thus far, 2,461 women have been enrolled in the program. In this group there have been found 30 carcinomas of the uterus, or 1.2 per cent. Twenty-three, or 76.7 per cent, were of the cervix and 7, or 23.3 per cent, were of the fundus. The age range for the cervical carcinoma group was from 26 to 70 years (average, 48.9

years), and for the fundal carcinoma group from 43 to 70 (average 59.1 years).

In evaluating the percentage of error of the vaginal smear method only those cases in which there was a check by biopsy of the cervix or endometrium, or both, were used. At present the percentage of error is 10.8, of which 7.5 per cent were false positives, and 3.3 per cent were false negatives. The false positive cases were submitted to biopsy, but otherwise they suffered no great harm. The false negative cases comprise the serious errors because these patients may be allowed to progress to late stage of cancer. It would seem advisable therefore to err on the side of making too many rather than too few biopsies.

Whatever the percentage of error may be the number of early carcinomas which have been found in the program thus far amply justify, in our opinion, the effort expended. To date eight cases have been found in which neither the symptoms nor the physical examination had led the patients' physicians to suspect cancer. In each of these cases the finding of abnormal cells in the smear was responsible for the performance of a biopsy which showed carcinoma of the cervix in five cases and carcinoma of the fundus in three cases. Of more importance is the fact that each of these cases was discovered in an early state and the possibilities of cure are excellent.

SUMMARY

In summary it may be said that the vaginal smear when applied as a community program to a large group of women, appears to discover early, and even symptomless, carcinoma of the uterus. The program can be operated by practicing doctors who make the pelvic examination and take the smear, in cooperation with pathologists who must be specially trained in evaluating the smears. In the operation of such a program the limitations of the vaginal smear must be strictly evaluated in order to prevent serious error. The usefulness of the test may be summarized as follows:

1. The test is not a substitute for biopsy. If the clinical picture is suspicious, a biopsy should be performed even though the smear is negative.
2. The test is not diagnostic. It is a screen test and only points the way for further definitive procedures. No therapeutic measures should be undertaken without confirmation of the smear findings by biopsy.
3. It is of special value in two types of cases:
 - a. The clinically suspicious case. Here it will aid in the selection of the proper case for biopsy.
 - b. The clinically well case. Here it may detect carcinoma before there are any clinical signs or symptoms.

Curable Forms of Heart Disease

A. CARLTON ERNSTENE, M.D., and WILLIAM L. PROUDFIT, M.D.

THE progressive increase in the incidence of organic cardiac disease during the past forty years has been a powerful stimulant for research on all disorders of the heart and circulation. Unfortunately the anatomic changes in heart disease due to rheumatic fever, hypertension, and coronary arteriosclerosis are not reversible. Ultimate control of these major components of the cardiovascular problem, therefore, must await the development of knowledge upon which effective prophylactic measures can be based. Several cardiac conditions, however, have been shown to be susceptible to cure by medical or surgical treatment. Although these conditions comprise only a small fraction of all cases of heart disease, it is important that they be recognized when present and that one be acquainted with the available therapeutic measures. The clinical characteristics and treatment of the various curable disorders will be discussed in the present communication.

THYROTOXIC HEART DISEASE

Dyspnea on limited exertion, palpitation, tachycardia, and systolic murmurs at the cardiac apex or over the pulmonary area are commonly present in patients who have uncomplicated hyperthyroidism. These features are the result of circulatory adjustments to meet the increased metabolic needs of the body and are not to be interpreted as evidence of myocardial damage. Thyrotoxicosis may be accompanied, however, by more important cardiovascular complications, and it is to these that the term thyrotoxic heart disease is properly applied. Correction of the hyperthyroidism results in their complete and permanent control.

Thyrotoxic heart disease causes no characteristic gross or microscopic changes in the heart. Although cardiac hypertrophy is present in one-half of all patients who die of hyperthyroidism or after thyroidectomy, it has been demonstrated¹ that this hypertrophy is almost always associated with myocardial failure, auricular fibrillation, essential hypertension, or severe coronary artery disease. Even in uncomplicated thyrotoxicosis, however, comparison of tele-roentgenograms made before and after thyroidectomy may reveal diminution in size of the heart after operation, and this, of course, indicates that hyperthyroidism alone is capable of causing an appreciable degree of reversible dilatation of the heart.

¹ Presented in abstract before the Section on Medicine at the Annual Meeting of the Ohio State Medical Association at Cincinnati, March 30, 1948.

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The two most important clinical manifestations of thyrotoxic heart disease are auricular fibrillation and congestive heart failure.² Auricular fibrillation occurs in its continuous form or in paroxysms of variable duration in about 10 per cent of all patients with hyperthyroidism, and in another group of the same numerical size the arrhythmia develops as a temporary complication of the early postoperative period. Approximately one-half of the patients present evidence of some form of organic heart disease, but in the remainder there are no abnormal cardiac findings other than the irregular rhythm and possibly some slight enlargement of the heart on roentgenologic examination. After thyroidectomy the cardiac rhythm reverts spontaneously to normal in nearly one-half of the patients, and in about one-half of the remainder sinus rhythm can be re-established by the administration of quinidine sulfate. Persistence of auricular fibrillation in spite of the proper use of quinidine indicates that some factor in addition to thyrotoxicosis was responsible for the development of the arrhythmia and calls for the continued administration of maintenance amounts of digitalis.

Congestive heart failure occurs in approximately 4 per cent of all thyrotoxic patients. The two most important factors responsible for its development are uncontrolled auricular fibrillation and the presence of organic heart disease. Auricular fibrillation is present in two-thirds of the cases and at times appears to be the only cause of the failure. The majority of patients, however, either present evidence of organic heart disease or are of such an age that the possibility of changes in the coronary arteries cannot be excluded. Even in these patients, thyroidectomy

after adequate preoperative treatment usually results in sufficient improvement in myocardial reserve so that normal activities no longer cause cardiovascular symptoms.

Although recognition of classical hyperthyroidism and evaluation of the accompanying cardiac findings are relatively easy, there is a group of cases which presents a more difficult diagnostic problem. In this group, the symptoms and signs of thyrotoxicosis are not at all in evidence, and the clinical picture is dominated by manifestations of myocardial insufficiency. Exophthalmos and other abnormal eye signs are absent, and there may be little or no enlargement of the thyroid gland. The presence of so-called "masked hyperthyroidism" usually is overlooked for some time, and the patient is treated, with little or no success, as if he had primary cardiovascular disease. A careful history and physical examination, however, reveal certain features which should suggest the possibility of thyrotoxicosis. Nervousness, tremor, diminished tolerance to heat, and weight loss in spite of a satisfactory appetite usually are present at least to a slight degree. Increased warmth and moisture of the skin, a peculiar flushed appearance of the face and neck, and the presence of a hyperactive heart with a snapping first sound also are helpful diagnostic features. Of particular importance, however, is the occurrence of auricular fibrillation in either its paroxysmal or continuous form. Frequently it is this that first suggests the true nature of the illness. Several observers have expressed the opinion that the presence of auricular fibrillation always should lead one to consider the possibility of hyperthyroidism even though obvious organic heart disease is also present.

MYXEDEMA HEART

Myxedema is usually accompanied by changes in the electrocardiogram, the most characteristic of which are iso-electric or inverted T waves in all leads. The P waves and QRS complexes are frequently of subnormal amplitude also. Tele-roentgenograms of the thorax often show an increase in the size of the heart shadow, and fluoroscopic examination reveals sluggish cardiac movements. These are the essential features of myxedema heart. The increase in the size of the heart probably is due principally to dilatation, but interstitial edema may also play a part. At postmortem examination the weight of the heart may or may not be increased, and histologic studies³ show degenerative changes in the heart muscle cells. Coronary artery sclerosis is often present.

Myxedema heart may cause no symptoms, but slight to moderate dyspnea on exertion is common, and when severe thyroid deficiency has been present for a long time or occurs in an elderly person, congestive heart failure may

develop. An occasional individual experiences attacks of angina pectoris.

In uncomplicated cases, thyroid substance completely corrects the electrocardiographic abnormalities of myxedema and restores the heart to normal size. Digitalis should be administered to those patients who have congestive heart failure but will be only partially effective as long as the myxedematous state remains uncorrected. Overdosage with thyroid substance must be carefully avoided, and whenever there is myocardial failure, considerable enlargement of the heart, or a history of angina pectoris, only small amounts should be given. The effect of treatment on the basal metabolic rate, electrocardiogram, and size of the heart should be checked at frequent intervals, and as soon as the maximum degree of improvement has been attained the daily dose should be reduced to the lowest level that will maintain this state.

BACTERIAL ENDOCARDITIS

Prior to the introduction of penicillin therapy, bacterial endocarditis was almost invariably a fatal disease. Treatment with this antibiotic agent, however, results in the cure of approximately 75 per cent of all patients who have the common subacute variety, and successful results also have been reported in cases of the uncommon acute type due to such organisms as the meningococcus, staphylococcus aureus, and hemolytic streptococci. Large amounts of penicillin must be given in all cases, and treatment should be continued for at least three weeks. Continuous intramuscular or intravenous administration may be employed, or intramuscular injections may be given at two-hour intervals day and night. A daily total of 600,000 units is sufficient in a majority of the cases. The penicillin sensitivity of the infecting organism should be measured whenever possible, and Dawson and Hunter⁴ advise that the dosage of penicillin be sufficient to maintain a serum level at least four times as high as the concentration required to inhibit the growth of the organism in vitro. They have published a table which can be used as a guide to the amount required to obtain this level when continuous intramuscular administration is used.

In some of the earlier work, it was recommended that heparin be given to patients receiving antibiotic treatment for bacterial endocarditis. Increasing experience has failed to demonstrate that the results from combined therapy of this type are superior to those obtained with penicillin alone. Because of this and the danger of hemorrhage which attends the use of anticoagulants in patients who have bacterial endocarditis, there is now general agreement that heparin should not be employed in the treatment of this condition.

After completion of a course of penicillin

therapy, the patient should be examined at frequent intervals for clinical evidence of persistence of the infection, and the blood culture should be checked periodically. In unsuccessful cases, relapses most commonly become apparent within the first two weeks after the termination of treatment, but in unusual instances the patient may experience a recurrence after an interval of several months. In the latter cases it may be difficult to determine whether the return of symptoms and positive blood cultures is due to a relapse or to reinfection.

In a certain number of patients who have bacterial endocarditis, congestive heart failure develops either during the course of the illness or within a few weeks after completion of treatment with penicillin. This complication probably is due principally to an accompanying myocarditis but another factor may also be of importance in those cases in which evidence of decompensation appears during the post-treatment period. After the vegetations of bacterial endocarditis have been sterilized by penicillin the process of healing in the lesions often require three months or more for completion. During this period the affected heart valves may be subjected to additional distortion because of scar tissue contraction, and this may place a considerably added strain on the myocardium. The patient, therefore, should be kept under close observation and must not be allowed to increase his activities too rapidly.

BERIBERI HEART DISEASE

This is an uncommon form of heart disease which is due to thiamine deficiency and in the western hemisphere is almost always associated with chronic alcoholism. Because of the latter feature it is encountered more frequently in the wards of large municipal hospitals than in private practice. The condition causes congestive failure which cannot be distinguished on the basis of symptoms and physical signs from failure due to other forms of heart disease. The patients generally are beyond the age of 40 years, and many cases undoubtedly are erroneously considered to be instances of coronary heart disease.

One of the most helpful diagnostic features of beriberi heart disease consists of a normal or increased velocity of blood flow in the presence of myocardial failure. This unfortunately is not a uniform finding, and there are many cases in which the blood velocity is reduced just as it is in decompensation due to other causes. Blankenhorn⁵ has pointed out, however, that other diagnostic criteria are available. He places particular emphasis on the occurrence of otherwise unexplainable congestive failure in a patient who presents signs of neuritis or pellagra and gives a history of having taken

a thiamine deficient diet during the preceding three months or more. The heart is enlarged but its rhythm is not disturbed, and the electrocardiogram shows no more than minor changes. Recovery is attended by a decrease in the size of the heart, and in fatal cases the necropsy findings are consistent with thiamine deficiency.

Because the presence of beriberi heart disease often is not recognized until the patient's condition has become critical, the mortality rate is high. The response to treatment with thiamine is usually slow, but in favorable cases complete recovery occurs. Digitalis and a low sodium diet should be administered as in congestive failure due to other causes but do not produce a satisfactory response unless the intake of thiamine is increased at the same time.

CHRONIC CONSTRICTIVE PERICARDITIS

One of the most important advances in surgery in recent years has been the development of technics for the cure of certain cardiac conditions. The earliest of these procedures and the one that has yielded the most dramatic results consists of resection of a pericardial scar for the relief of chronic constrictive pericarditis. The operation has now been performed on a large number of patients,^{6,7,8,9,10} but the condition is still being overlooked or not recognized until it has reached an advanced stage. One reason for this is the insidious onset and slow progression of the illness, but of greater importance is failure to evaluate correctly the characteristic combination of physical signs to which the condition gives rise. These signs are a direct result of the fact that in chronic constrictive pericarditis the heart is surrounded by a firm, vice-like scar which interferes with diastolic relaxation of the ventricles and prevents hypertrophy and dilatation. The peripheral venous pressure is elevated, and there is usually moderate or severe cyanosis. The liver is enlarged and ascites is present, often far out of proportion to the degree of edema of the lower extremities. In contrast to these findings, roentgenograms show the heart shadow to be of normal size or at the most only slightly enlarged. Depositions of calcium are seen at times in the pericardial scar, and fluoroscopic studies or roentgen kymograms reveal greatly diminished cardiac excursions. The heart sounds are faint, and no murmurs are present. The systolic blood pressure is low, and the pulse pressure is reduced. Electrocardiograms may show low voltage of the QRS complexes and fixation of the electrical axis.

Treatment of chronic constrictive pericarditis by the measures employed in the management of congestive heart failure is of no value. The problem is a surgical one, and a successful operation results in complete and permanent relief of the cardiovascular symptoms and signs. In

long-standing cases, however, there may be evidence of residual cirrhosis of the liver as a result of the prolonged hepatic congestion.

PATENT DUCTUS ARTERIOSUS

Patent ductus arteriosus, one of the most common forms of congenital heart disease, can be recognized with great accuracy and can be cured by ligation or section of the ductus. The pathognomonic sign of the condition consists of a continuous murmur of machinery quality in the pulmonary area, beginning in systole and carrying well over into diastole. A palpable thrill is frequently present in the same region. Roentgenologic examination often shows prominence of the pulmonary artery and hilar vessels and not infrequently enlargement of the left ventricle. Fluoroscopy of the chest reveals active pulsation of the pulmonary vessels. The diastolic blood pressure is often reduced and the pulse pressure increased. The electrical axis of the electrocardiogram is usually normal.

Although occasional individuals with patent ductus arteriosus live to an advanced age, the condition is not a benign one. Bullock, Jones, and Dolley¹¹ collected data on 80 patients over three years of age and found that one-half had died before the age of 30 years and 71 per cent before the age of 40 years. The two most common causes of death were bacterial endarteritis and congestive heart failure.

The first successful ligation of a patent ductus arteriosus was performed by Gross and Hubbard¹² in 1939, and Shapiro¹³ recently was able to collect information on 626 cases in which either ligation or section had been done. Section of the ductus has become the procedure of choice because it eliminates the possibility of recanalization. Shapiro reported that of 182 patients without subacute bacterial endarteritis in whom section was performed, only one died. There is now general agreement that the operation should be advised in all children and young adults regardless of whether or not the condition has produced symptoms of cardiac enlargement. Even though a child has had no symptoms, there frequently is a surprising improvement in general health after the operation, and young adults who had not been aware previously of a handicap often report a remarkable increase in their sense of well-being. Surgical treatment is indicated also in all patients who have bacterial endarteritis and in older individuals in whom the heart is enlarged or there is evidence of beginning impairment of myocardial reserve.

COARCTATION OF THE AORTA

The most recent addition to the group of cardiac conditions that can be corrected by surgical treatment is coarctation of the aorta. In this anomaly a short segment of the aorta

in the region of the ligamentum arteriosum is constricted, and the lumen of the vessel is usually reduced to a diameter of 6 mm. or less. The circulation to the portion of the body below the level of stenosis is maintained by anastomoses between branches of the subclavian and axillary arteries and the intercostal arteries which arise from the aorta below the site of constriction. These collateral pathways make themselves apparent clinically by roentgenologic evidence of erosion of the subcostal grooves of the ribs and frequently also by the presence of pulsating vessels over the back, epigastrium and lower anterior thorax. Because of the resistance offered to the flow of blood by the narrowed aorta and the anastomotic pathways, the arterial pressure is elevated in the arms and reduced in the lower extremities, and the pulsations in the abdominal aorta and femoral arteries are greatly diminished or absent. The presence of coarctation of the aorta is often overlooked, but this error can be avoided if one makes it a practice to palpate the abdominal aorta and femoral arteries in every patient in whom the brachial blood pressure is elevated.

Although an occasional individual with coarctation lives to old age, Reifenshtein, Levine, and Gross¹⁴ found in a recent study of 104 autopsied cases that 61 per cent of the patients died before or during their fortieth year of life. The most common causes of death were rupture of the aorta, bacterial endocarditis or aortitis, congestive heart failure, and intracranial hemorrhage.

Successful operations for the correction of coarctation of the aorta have been reported by Gross,¹⁵ Crafoord and Nylin,¹⁶ and Clagett.¹⁷ The usual procedure has consisted of resection of the constricted segment of the aorta and re-establishment of the continuity of the vessel by end-to-end anastomosis. Clagett,¹⁷ however, because of the anatomic conditions encountered in his case, carried out a modification of the procedure suggested by Blalock and Park.¹⁸ After resecting the narrowed segment of the aorta, he sectioned the left subclavian artery and then performed an anastomosis between the proximal end of this vessel and the distal end of the aorta. In children and adolescents, a successful operation results in correction of the hypertension in the upper part of the body and the appearance of normal pressure and pulsations in the arteries of the legs. In older patients, on the other hand, some residual elevation of the brachial blood pressure may remain.

SUMMARY

Although organic heart disease can be expected to remain the leading cause of death until knowledge is acquired upon which to base effective prophylactic measures against rheumatic

fever, hypertension, and coronary arteriosclerosis, there are several cardiovascular conditions which can be cured by medical or surgical treatment. The most important of these are chronic constrictive pericarditis, patent ductus arteriosus, coarctation of the aorta, bacterial endocarditis, and heart disease due to thyrotoxicosis, myxedema, and beriberi.

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General Practitioner and Tuberculosis

Much could be learned about the epidemiology of tuberculosis if we could encourage the participation of more general practitioners in field studies throughout the country. The routine use of the tuberculin test on every person who visits the rural doctor's office would uncover a surprising number of hidden and unsuspected cases of tuberculosis. The examination of family contacts and a search for the original spreader leads the family physician away from his relentless daily routine into exciting by-paths of epidemiologic investigations. Through the utilization of modern methods of diagnosis and follow-up the rural physician extends the frontiers of knowledge of this puzzling disease.—Herman E. Hilleboe, M.D., *Journal-Lancet*, June, 1947.

KEEPING UP WITH MEDICINE

- If there had not been a single other evil consequence of Negro slavery in America then by the importation of malaria, the white man was fully paid for his wickedness.

* * *

- FOOD yeast as a source of protein may be somewhat inferior to animal proteins in human nutrition because of its deficiency in sulphur-containing amino-acids.

* * *

- ONE SHOULD always understand how the patient feels and conduct oneself with due consideration for the validity of his feelings.

* * *

- PHYSICAL treatments such as a change to a warmer climate, ultraviolet lamp, and diathermy speed up the pathologic processes in rheumatoid arthritis and so are contraindicated.

* * *

- STEVENS-JOHNSON Syndrome is an erythema exudative multiforme bullosum which some think to be an allergic response.

* * *

- ROUGHLY one child in two hundred is allergic to rice.

* * *

- INFANTS retain 74 per cent of the iron of human milk but only 34 of that from cow's milk.

* * *

- THE maxillary sinus is present at birth. It is of clinical significance at all ages.

* * *

- THE anemias of infancy have not been so well investigated or as thoroughly as those of adult life.

* * *

- TYROTHRICIN is said to be definitely more effective in early fall and late spring colds than in winter colds.

* * *

- ASPIRIN allergy is frequently associated with severe asthma and makes for a very poor prognosis.

* * *

- RECENT writings on the subject deny emphatically that overuse of the brain will hasten the aging process. On the contrary, they say aging is likely to be faster in a little-used brain.

* * *

- IT cannot be too strongly emphasized that while infected milk is the source of most epidemics of Brucellosis, almost all isolated cases can be traced to contact sources.—J. F.

Hyperinsulinism: Relief of Hypoglycemia by Removal of a Pancreatic Islet Cell Adenoma

LAWRENCE N. IRVIN, M. D., TOM D. JOHNSON, M. D., and DANIEL P. FOSTER, M. D.

SPONTANEOUS hypoglycemia is a fairly common disorder, characterized by an unusually low blood sugar. The condition was first recognized as early as 1849 when Claude Bernard first demonstrated its existence experimentally.¹ Hypoglycemia represents a disturbance in the carbohydrate metabolism and, as shown by Conn's² comprehensive and complete etiologic classification, may be due to a variety of disturbed functions. Certain cases of hypoglycemia result from a damaged liver, others from endocrine disorders, and some from dysfunction of the autonomic nervous system. The patient is often thought to be neurotic.

A few cases of spontaneous hypoglycemia are purely pancreatic in origin and are the direct result of an overproduction of insulin. Hyperinsulinism is the term applied to the cases of hypoglycemia resulting from such excess in insulin production. Seale Harris³ reporting on five cases of spontaneous hypoglycemia in which one reacted similarly to a diabetic with an overdose of insulin, first used the term "hyperinsulinism" in 1924. It is a relatively infrequent cause of hypoglycemia.

Hyperinsulinism occurs from simple hyperplasia or from benign or malignant adenoma of the islet cells. Surgical exploration is indicated when a member of this group is suspected. It was not until 1929 that Howland⁴ obtained the first recovery following surgical removal of an islet cell adeno-carcinoma. Walker and Boger⁵ collected only 56 operated cases of the adenoma type up to February, 1945. Duncan⁶ states that a large Veterans Administrative Hospital experienced only one case in 18,000 admissions. In over 500,000 admissions at the Henry Ford Hospital there have been only five cases of hyperinsulinism operated upon as of this date. This case report is illustrative of the very uncommon islet cell adenoma with hyperinsulinism and the excellent response with recovery after surgery.

CLASSIFICATION

Conn² suggested a brief and concise classification of the causes of hypoglycemia which include from 80 per cent to 90 per cent of all cases.

1. **Functional:**—Very common. Represents 70 per cent of all the hypoglycemias. Is due to

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a disturbance in the regulation of the blood sugar level by the autonomic nervous system. Treatment is medical.

2. **Organic:**—Always pancreatic in source. The hyperinsulinism results from a hyperplasia, a malignant or a benign islet cell adenoma. Requires surgery.

3. **Hepatogenic:**—The hypoglycemia results from a disturbance in the liver. Normal blood sugar cannot be maintained due to derangement of both gluconeogenesis and glycogenolysis. Treatment is generally medical except for a select few who are benefited by cholecystectomy.

An additional Miscellaneous Group might be added to the above three groups to include hypoglycemia due to pituitary and adrenal disturbances, to metabolic derangement such as seen with malnutrition and in renal glucosuria, and from central nervous system lesions. All of the cases included in this miscellaneous group will total only 10 per cent to 20 per cent of all cases of hypoglycemia, and most of them can be identified quickly.

DIAGNOSIS

Since the treatment of the "Organic Group" is ultimately surgical the importance of recognizing it is apparent. The perfecting of a direct measurement of the blood for insulin will be of great assistance in diagnosis. Some research about this is being done. After first ruling out the extrapancreatic causes of hypoglycemia, the following three clinical and laboratory points, derived with some variation from Whipple's triad, need be satisfied in order to make a diag-

Submitted February 18, 1948.

nosis of organic hypoglycemia. One can then predict with fair degree of accuracy the presence of an islet cell adenoma and proceed with surgery.

1. Definite symptoms of hypoglycemia (hunger, weakness, sweating, trembling, confusion, and perhaps visual and speech disturbances) progressive in frequency and severity; the attacks being precipitated by delayed food intake or exercise and definitely relieved by eating.

2. Progressive decline of blood sugar level to below 50 mgs./per cent by a prolonged fast which in our opinion should be extended beyond the usual twelve-hour interval if inconclusive at that time. The patient should be ambulatory and under observation for severe hypoglycemic reactions. Blood sugar determinations are made regularly. We feel that the most useful and reliable test is the characteristic blood sugar curve of the organic group to decline steadily, in contrast to the Functional Group whose blood sugar curve will eventually tend to return toward normal spontaneously. Subjective exaggerations of the functional case are to be evaluated critically.

3. Dramatic and immediate relief of symptoms by intravenous glucose administration.

The presence of a morning fasting blood sugar of 50 mgs./per cent or less, frequently mentioned in the literature as characteristic of Organic Hypoglycemia, is of assistance in arriving at the diagnosis of hyperinsulinism. Its absence however does not necessarily rule out the diagnosis as this case report illustrates. Many factors affect the level of the morning fasting blood sugar such as the state of nutrition of the patient and his glycogen stores, the amount of restlessness the patient experienced during the night, the degree of activity of the pancreatic islets, the unpredictable degree of liver response in carbohydrate metabolism, etc. Also the time element may be insufficiently long in the usual twelve-hour fast to demonstrate the typical picture of marked hypoglycemia with hyperinsulinism.

There are considerable differences of opinion concerning the diagnostic value of the glucose tolerance curve. Duncan⁸ feels "that evidence of a remarkable increase above the normal rate at which glucose is removed from the blood should be demonstrable in every case of hyperinsulinism." In contrast, Conn⁹ points out that about 50 per cent of the hyperinsulin cases have responded with a hyperglycemic plateau type of curve. He postulates that the presence or absence of such a curve is dependent upon the functional state of the pancreas proper. Further, that this functional state is conditioned by the intensity of the hyperinsulinism produced by the

abnormal adenomatous tissue. In other words, the more severe the hyperinsulinism resultant from an adenoma, which Himwich¹⁰ found will continue to secrete insulin without the usual body regulation, the greater is the depression of the function of the normal islets. Consequently the less likely is one to see a rapid fall to hypoglycemic levels.

SURGICAL INDICATIONS

Those cases meeting the original criteria of Whipple for predicting the presence of an adenoma could expect an accuracy of 83 per cent. Conn¹¹ with much more severe criteria in 1940 and revised in 1947,² anticipates the presence of an adenoma correctly in virtually all cases. The experienced surgeon is aware that a small adenoma is extremely difficult to palpate, and the occurrence frequently of multiple adenoma and ectopic pancreatic tissue adds greatly to his problem.

When, by the criteria selected, the diagnosis of hyperinsulinism has been established, no benefit and often harm can result from deferring surgical intervention, since:

1. Medical management of these cases is eventually unsuccessful.

2. Characteristically, the adenoma will relentlessly progress and produce increasing severity and frequency of the symptoms.

3. Himwich¹² has shown that brain tissue differs from all other body tissue in obtaining its energy from oxidizing carbohydrate exclusively. Therefore, as Hoefer¹³ points out, interference with the general carbohydrate metabolism leads to marked changes in the activity of the central nervous system. According to Malamud,¹⁴ there is the possibility that these changes in the cortex and basal ganglia may become irreversible with the advancing destruction.

4. The gain in weight in some patients resulting from an attempt to alleviate their symptoms by overeating and by taking food between meals, increases the surgical risk.

CASE REPORT

Case of J.L.P., Italian female, aged 29, married, three children, was seen in the outpatient department on April 15, 1947, complaining of episodes characterized by confusion, blurring of vision, thick speech, headaches, weakness, sweating, hunger, parasthesiae, and if not arrested by eating, would progress to disorientation and impairment of memory. Attacks were progressing in frequency and severity for the past one and a half years. They were provoked by delayed or missed meals, fatigue, menstruation, and especially exercise. Recovery would not occur spontaneously, and the symptoms would increase unless food was injected. Extra food had frequently been taken to avert the disagreeable and frightening symptoms. The result was a 30-pound weight gain. Attempts to

reduce this weight by decreasing the diet had always aggravated the symptoms.

Physical Examination:—Normal, composed, Italian woman with moderate obesity; height 5 feet 6½ inches; weight 169 lbs.; hair oily and normally distributed. Skin soft with no icterus or abnormal pigmentation; tongue moist and rough. No lymphadenopathy. Thyroid not palpable. Chest and heart findings normal. Blood pressure 120/78. No masses or tenderness in abdomen. Reflexes normally active and equal. Pelvis not abnormal.

Some differential studies were begun in the outpatient department. In one of the patient's attacks of mental confusion and hypoglycemic disorientation at home, she went without food for forty-six and one-half consecutive hours. She was then admitted to the hospital in a dazed state on May 24, 1947. Blood sugar taken immediately was 32 mgs./per cent.

LABORATORY DATA

Urinalysis normal. Red blood count 4,700,000; hemoglobin 14.3 gms.; white blood count 8,800; polymorphonuclear neutrophil leukocytes 58 per cent; Kline exclusion negative.

DIFFERENTIAL STUDIES

Bromsufalein 45 and 60 minutes, no retention. Cephalin cholesterol, negative. Thymol turbidity, 1 unit. Thymol flocculation, negative. Serum sodium, 310 mg./per cent. Serum potassium, 15 mg./per cent. Electroencephalogram taken during a fasting and confused state was essentially normal with low voltage record. Skull and sella turcica X-rays, not abnormal. Gastro-intestinal X-rays showed normal stomach, normal cap, and proper curve of duodenum. Non-functioning gallbladder. No calcifications of adrenals seen. Oral glucose tolerance curves were of no assistance in differential diagnosis.

Preoperative twelve-hour fasting (prebreakfast) blood sugars varied between 70 and 94 mgs./per cent (Chart A). But when this fast was continued beyond the customary twelve hours, the blood sugar levels dropped precipitantly to a low of 37 mgs./per cent in twenty-eight hours, and the fast had to be discontinued due to the extreme severity of the symptoms (Chart B).

Postoperatively, the fasting morning blood sugar varied between 129 mgs./per cent six hours after surgery and 94 mgs./per cent a few days later. The hyperglycemia seen soon after surgery is characteristic. Normal level is reached in a short time (Chart A). A week later the prolongation of a fast for 40 consecutive hours produced none of the former hypoglycemic symptoms. The blood sugar level could not be forced lower than 97 mgs./per cent (Chart B).

Glucose tolerance curve (intravenous) preoperatively, after three days of a high carbohydrate diet, showed a progressive terminal decline to 52 mgs./per cent at the end of five and one-half hours. Postoperatively the curve showed a tendency to rise terminally to 87 mgs./per cent in the same length of time (Chart C).

Respiratory quotient curves showed a greater degree of carbohydrate oxidation preoperatively than postoperatively (Chart D).

OPERATIVE REPORT

The patient was operated on June 6, 1947, by Drs. Roy McClure and Brock Brush with their description following:

" . . . pancreas is thin and normal in size and appearance throughout, except for one

little nodule in the head of the pancreas This is shelled out we again explore the remainder of the pancreas carefully and are unable to feel any other nodular pathology we also examine for ectopic pancreatic tissue and do not find any present."

In addition, a cholecystectomy was performed for a chronic cholecystitis with cholelithiasis.

mgs/100 cc.
140

130

120

110

100

90

80

70

60

Preoperative

Postoperative

Chart A: Fasting Daily Blood Sugar.

mgs/100 cc.

110

100

90

80

70

60

50

40

30

12 16 20 24 28 32 36 40 hours

--- Preoperative
— Postoperative
..... 6 months postoperative

Chart B: Blood sugar taken every four hours on prolonged fast.

An appendectomy was done. Also a simple cyst was found in the right ovary.

PATHOLOGICAL REPORT

The diagnoses include chronic appendicitis, chronic cholecystitis with cholelithiasis, and an islet cell adenoma of the pancreas. The latter is described as follows:

" The tumor from the pancreas is encapsulated and measures 1.5 cms in diameter Section shows a well defined capsule of dense white fibrous connective tissue. . . . Bulk of the tumor is made up of small masses of epithelial cells which resemble Islands of Langerhan. . . . The individual tumor cells have a uniform medium sized, moderately dark staining nuclei, and relatively little pale staining cytoplasm. These cells are arranged in small anastomosing cords separated by small capillaries."

POSTOPERATIVE RESULTS

The postoperative results were spectacularly beneficial. Her recovery was uneventful except for three short episodes of recurrent pancreatitis within the first seven weeks after surgery. Now, seven months later, she shows normal findings even after a 36-hour continued fast (Chart B). She has lost 18 pounds in weight and can tolerate a low caloric diet.

DISCUSSION

The symptoms presented by this patient were typical of hypoglycemia. Blood sugar determinations confirmed this diagnosis.

Other extrapancreatic factors were excluded by appropriate investigations as etiological possibilities. Liver function tests did not support a hepatogenic etiology. The electroencephalogram did not present any evidence of epilepsy or central nervous system pathology.

The steadily increasing severity of the hypoglycemia without any tendency for the blood sugar level to return toward normal, even after an extended fast, is the strongest evidence in favor of true hyperinsulinism as opposed to the functional etiology of the hypoglycemia.

The duplication of all the symptoms and findings by controlled fasts with dramatic relief by the intravenous administration of glucose, further established the diagnosis of true hyperinsulinism. Surgery seemed definitely indicated.

Of interest in this case is the type of preoperative glucose tolerance curve which does not show a rapid fall to hypoglycemic levels as might be expected in cases of hyperinsulinism. Conn⁹ recently pointed out that as many as 50 per cent of cases of hyperinsulinism may not demonstrate this point. This should not be misleading. He points out that the antecedent diet and the severity of the excessive insulin production by the abnormal pancreatic tissue, accompanied by the consequent depression of the ability of the normal islet cells to respond to a test dose of glucose,—may account for this type of curve.

The fact that the twelve-hour fasting blood

sugar taken in the morning before breakfast and preceding the daily activity were relatively normal, illustrates the importance of a more prolonged fast (Chart A). This may be especially valuable in differentiating hyperinsulinism from other causes of spontaneous hypoglycemia.

SUMMARY

A case of hyperinsulinism is presented, completely relieved of all symptoms by the surgical removal of a pancreatic islet cell adenoma.

The differential diagnosis of hyperinsulinism

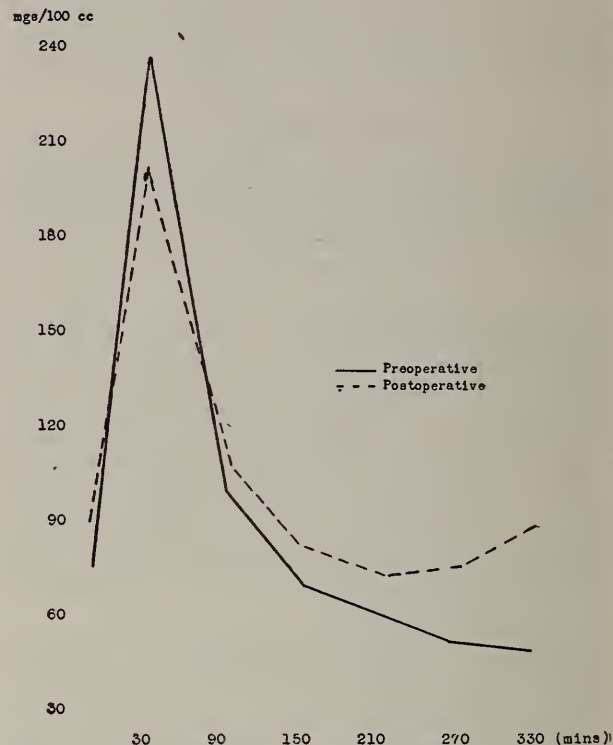


Chart C: Five-and-a-half-hour intravenous glucose tolerance.

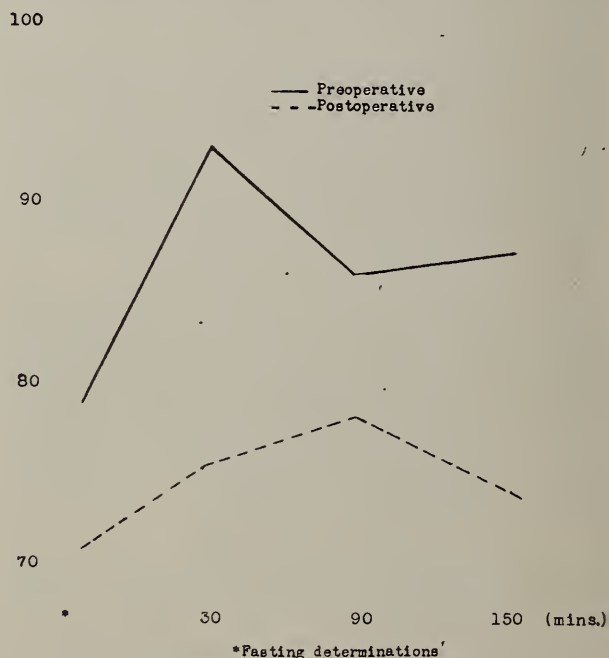


Chart D: Respiratory quotient.

from the other causes of spontaneous hypoglycemia is discussed.

A concise etiologic classification of spontaneous hypoglycemia is suggested. The criteria to be met indicating surgery in hyperinsulinism are listed.

The failure of the short all-night fasting time to demonstrate marked hypoglycemic levels and the advantage of the prolonged fast is illustrated in this case.

Histological evidence supported the diagnosis of pancreatic islet cell adenoma.

Seven months postoperatively, the clinical and laboratory check of the patient illustrate the excellent results to be obtained by surgical removal of the adenoma in cases of hyperinsulinism.

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Diet of the Tuberculous Patient

The tuberculous patient should receive more than one gram of protein per day, and the diet must supply enough calories to balance his energy requirements. The calories supplied by carbohydrates and fats must contribute to the total fuel value, in such a proportion that the calories from fats should not fall below 30 per cent or exceed 40 per cent. If the patient receives a diet adequate in all respects and supplying a sufficient amount of protein, it is very probable that his body will store proteins for his repairing needs, just as would be the case in an ordinary individual.—J. D. Adamson, M.D., *Canad. Tuberc. A. Tr.*, 1947.

Uterus Didelphys: Report of Case

Some degree of lack of fusion of the primitive structures which give rise to the uterus is stated to occur once in every 15,000 obstetrical cases, and uterine didelphys once among 28,000 women. Pregnancy progressing to full term in the latter anomaly is sufficiently unusual to warrant the report of a case.

CASE REPORT

The patient, a primipara 30 years of age, presented herself on November 25, 1946, when she was found to be ten weeks' pregnant. Pelvic examination revealed adequate measurements and a gynecoid type of pelvis. Bi-manual examination revealed the vagina divided by a septum in the upper third and a small hard cervix on either side. The uterus felt completely separated into two organs. The right side was about the size of a ten weeks' gestation; the left side was soft and not enlarged. Examination through a speculum confirmed the presence of a vaginal septum and two cervices.

The menstrual history was normal. Menarche began at fifteen; the cycle was regular, occurring every 28 days; the flow was copious, lasting seven days and associated with pain only at the onset. The last menstrual period was September 2, 1946.

The only pertinent datum in the past history was a spinal fusion at the age of twelve for a spinal defect, the nature of which she did not know. There was no familial history of congenital defects.

The progress of the pregnancy was uneventful. Quickening was first noted at 18 weeks. There was a gain of 20½ lbs. in weight. An X-ray taken ten days before the date of expected delivery revealed a breech presentation of a normal sized fetus; there were no fetal or maternal osseous deformities. The presenting part was engaging.

At term she was given a test of labor for about twelve hours. The contractions were painful but ineffectual. During the last two hours they occurred every two or three minutes and lasted 30 to 45 seconds. The cervix remained thick and uneffaced and the presenting part failed to descend. Since no progress was observed, a low cervical Caesarean section under spinal anesthesia was performed and a normal female child weighing 7 lb. 4 oz. was delivered. The postoperative course was uneventful.

OPERATIVE FINDINGS

The usual picture of uterus didelphys was found. The right portion was enlarged to the size of a full term pregnancy. The left portion was hypertrophied to the size of about a three months' gestation. There was one cornu laterally with its tube on each segment of the uterus. The ovaries showed nothing remarkable. The lower sigmoid colon and rectum lay between the two halves of the uterus.

—L. D. BONAR, M.D.,
Mansfield, Ohio.

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Total vs. Subtotal Hysterectomy with Special Reference to Carcinoma of the Cervix—Analysis of 257 Personal Cases

JOHN J. McDONOUGH, M. D.

EACH year twenty thousand women die in this country of malignant disease of the uterus. A significant number of this group succumb to carcinoma in a retained cervical stump following hysterectomy. The purpose of this paper is to add one more plea for removal of the cervix when excision of the uterus is indicated.

During the past ten years numerous reports in the literature have compared the advantages and disadvantages of total and subtotal hysterectomy. Despite the flexible attitude taken by most authors, there is an unmistakable trend toward complete hysterectomy.

The salient reason for moving away from the time-honored subtotal procedure has been the gynecologist's responsibility for treating subsequent benign or malignant disease in the retained cervical stump. If the cervix is removed, it cannot become infected, degenerate, prolapse or become malignant. Moreover, surgical progress has made total hysterectomy a possible and safe operation.

The outstanding argument against total hysterectomy has been a mistaken charge of high primary mortality and morbidity. On the contrary, a careful survey of the recent literature shows that these factors actually are low. Moreover, in the series of 257 cases herein reported, the mortality rate is 0 per cent.

It was remarkable in this study that carcinoma of the cervix was discovered on routine histological examination in four instances when the hysterectomy had been performed for primary benign pathology in the uterine fundus. These cancers were definitely localized growths. They were not obvious on speculum examination, nor could they be detected on gross examination of the cervix when the organ had been removed. If these lesions had not been discovered until they could be classified clinically, only one in five of these patients could have been predicted to remain alive and well for five years, even though the best standardized treatment for carcinoma of the cervix was used.

TeLinde reports four cases of early cervical carcinoma in 300 hysterectomies performed for benign uterine disease. In these cases the cervixes were given very careful study, including biopsy of suspicious appearing areas, before hysterectomy. Despite all efforts to rule out early carcinoma in the cervix before hysterectomy, four in 300 did not disclose malignancy

The Author

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until serial sections of the cervix were taken after the organ had been removed. The finding of carcinoma of the cervix in this way leads one to a more careful scrutiny of all cervixes. One wonders so frequently, is this, or is it not a bad cervix? Perhaps the greater development of diagnosis by vaginal smear examination, confirmed by repeated cervical biopsy, will improve our diagnostic ability.

Aside from the development of carcinoma in the retained stump, subsequent infection or degeneration in it demands serious consideration. Hilliard Miller reports intractable leukorrhea, backache, and pelvic pain in 12 to 15 per cent of cervixes following supravaginal hysterectomy. The symptoms and physical findings were sufficient to require cauterization, conization or removal of the cervical stump.

Masson reports leukorrhea, occasionally blood-tinged and malodorous, following subtotal hysterectomy in patients who did not have these complaints before operation. Moreover, the vaginal surface of the cervix appeared normal. He believes that ligation of the uterine vessels and removal of the fundus interfere with the blood supply to the cervix and predispose it to infection and degenerative changes. Myositis, arthritis, and iritis have been traced to a chronically infected cervix. Urethritis and cystitis are commonly associated with chronic cervicitis. The urologist knows well that he cannot effectively treat a persistent infection in the bladder or urethra if a chronic cervicitis exists.

STUMP CARCINOMA

It is extremely difficult to arrive at the actual incidence of carcinoma of the cervical stump. Meigs believes it is 3 to 4 per cent. Masson, reporting 4,000 cases of carcinoma of the cervix from the Mayo Clinic, found 236 cases of cancer of the cervical stump, an incidence of 5.9 per cent. TeLinde believes that 3 per cent is about the average rate. Von Graff, reporting statistics

from both Vienna and the State of Iowa, places it at 8 per cent. These statistics are worth very little, because the true incidence could be determined only by following a group of women throughout their lifetime after supravaginal hysterectomy.

It has been repeatedly held that stump carcinomas are so few that they are not a valid indication for routine total hysterectomy. Admittedly this is a controversial subject, yet these same authors are themselves performing total hysterectomies almost exclusively. And although it is true we are in doubt regarding the accurate number of stump malignancies, we do know that they exist and that they constitute a real problem in treatment. If routine total hysterectomy were followed they need not exist at all.

The contention that operative mortality is higher than the incidence of stump malignancy is no longer tenable. Studies by Danforth, TeLinde, Heaney, Pratt, McDonald, and others, prove conclusively that total hysterectomy is a safe operation and should not carry a mortality of more than 0.5 to 1 per cent. In many large series of cases the rate will be less than 0.5 per cent as in the series reported herewith.

There appears to be a relationship between cervical cancer and fibroids. It has been estimated that 3 to 5 per cent of leiomyomata have, or develop, cervical malignancy. Also, it has been found that two-thirds of cervical stump malignancies follow supravaginal hysterectomy for myomas of the uterine fundus. Cauterization or conization will not prevent cervical malignancy, for Von Graff has shown that 8 per cent of carcinoma of the cervix occurs in the squamous epithelium of the portio vaginalis.

ANALYSIS OF CASES

Two hundred fifty-seven cases are presented in which hysterectomy was indicated. There were 170 total abdominal hysterectomies, 83 vaginal hysterectomies, and 4 subtotal abdominal hysterectomies. The indications for operation are revealed in the pathological diagnosis in Figure 1.

No distinction was made between benign or malignant disease, hoping to show that the primary mortality can be kept appreciably low in both instances. (It is not to be denied, however, that in two subtotal operations the pathological diagnosis was carcinoma of the ovary, and it was physically impossible to perform a complete hysterectomy. One patient is living, and one expired eight months following operation from generalized carcinomatosis.) The morbidity percentage was not calculated. It was somewhat higher in vaginal hysterectomy but the ultimate results were equally good in both types of operation.

It is often difficult to make a positive diagnosis of morbidity unless a definite complication exists. The patient may show an elevated temperature for one day or more, and this will be

FIGURE 1
INDICATION FOR HYSTERECTOMY

No.	Pathological Diagnosis
97	Fibromyomata
37	Pelvic Inflammatory Disease
34	Endometriosis
29	Descensus Uteri
13	Functional Bleeding (Hormonal dysplasia)
13	Chronic Cervicitis
7	Carcinoma of Fundus
6	Pelvic Tuberculosis
6	Multilocular Cyst Adenoma of Ovary
4	Ri-Lateral Dermoid Cyst
3	Carcinoma of Ovary
3	Endometrial Hyperplasia
2	Carcinoma of Cervix
1	Ruptured Uterus
1	Fibroid of Ovary
1	Chorioadenoma

the only sign of morbidity. Different constitutional types of patients will always make an absolute criterion of morbidity difficult.

In approximately half of the reported cases penicillin and sulfathiazole were used post-operatively. A study of these cases does not show conclusively that penicillin and sulfa will eliminate morbidity. Careful, meticulous surgery remains the best means of maintaining a low morbidity. However, despite all efforts, some morbidity continues in gynecological surgery as in nearly all types of surgery. Penicillin or sulfa has not completely changed the picture. On the other hand, intelligent use of all means at the surgeon's disposal, including the chemotherapeutic drugs, antibiotics, parenteral fluids, plasma, whole blood, new methods of anaesthesia, and early ambulation has unquestionably extended the field of surgical approach.

The oldest patient was 72 years old; the youngest was 18; and the average age was 43.5. Greater use of vaginal hysterectomy could have been made. It was used less often because of the difficulty in obtaining trained resident personnel. With one assistant it is often easier to perform an abdominal hysterectomy than a vaginal hysterectomy.

PROCEDURE

No originality of technique is proposed in this report. The abdominal hysterectomy is performed after the method of Baldwin. The Pfannenstiel incision was used in 75 per cent of the abdominal procedures. A dissection technique is followed in excising the uterus. The broad ligament is incised freely after the infundibulopelvic ligament is clamped, cut, and transfixed. All clamps are replaced immediately with transfixion sutures and removed from the

field as the operation proceeds. The uterine arteries are isolated and clearly defined before ligation. The bladder is freely mobilized and in most instances the vagina is entered through the anterior cul-de-sac. The round, utero-sacral, and cardinal ligaments are incorporated into the angle of the vaginal cuff, and the cuff closed with interrupted figure-of-eight sutures without drainage. An accurate peritonealization is performed.

The vaginal technique is carried out after the method of Heaney, and the anterior and posterior colporrhaphy performed as indicated. Interrupted chromic O is used throughout in the abdominal hysterectomy. Interrupted chromic I is used in the vaginal procedure. Early ambulation was routinely practiced in this group of cases. Ninety per cent were up on the side of the bed and onto the floor the first postoperative day. Thereafter their activity increased daily. Spinal anaesthesia was used in 95 per cent of the cases.

COMPLICATIONS

The complications are revealed in Figure II which follows:

FIGURE II
Complications

Type	Vaginal	Abdominal
Bladder	2	2
Ureteral		1
Intestinal Obstruction		1
Pelvic Abscesses	2	2
Incisional Abscesses		4
Atelectasis		1
Postoperative Hemorrhage	1	

There were four bladder injuries and one ureteral injury in the entire series. The bladder injuries were visualized at the time and repaired. Two occurred in the abdominal group and two in the vaginal series. In each case a retention catheter was kept in the bladder for seven days. Primary healing occurred in each instance. The ureteral injury was not discovered until the fourth postoperative day. Spontaneous closure occurred and intravenous urograms subsequently revealed a normally functioning kidney and ureter.

There was one postoperative intestinal obstruction, apparently due to sulfathiazole powder placed in the posterior cul-de-sac. This occurred in 1942. The obstruction was relieved surgically on the fourteenth postoperative day and the patient made a normal recovery. Two loops of small bowel were found imbedded in a mass of sulfathiazole crystals. It was my impression that the sulfa powder produced the obstruction by agglutinating one bowel loop to the other not permitting normal free peristaltic action. Since that time, I have never used any type of sulfa powder within the peritoneal cavity. Moreover, all studies indicate a greater therapeutic

value if sulfa is used either by mouth or intravenously during the postoperative period.

There were four postoperative pelvic abscesses. They were associated with a chill, a rise in temperature, and a discharge of a large amount of purulent exudate from the vagina. In three instances spontaneous evacuation occurred. In one case a posterior colpotomy was performed. In all cases complete resolution and healing followed.

There were six incisional abscesses. Two were in transverse incisions and four in the paramedial group. Spontaneous evacuation of the pus occurred in each instance following the use of warm, moist compresses. Complete wound dehiscence did not occur in any case. There were no postoperative herniations.

Atelectasis occurred in one instance. Conservative treatment, including penicillin and sulfa, was used. The total hospital stay was increased, but the lungs cleared completely in fourteen days. This patient refused to get up on her first or second postoperative day and this may have been a contributing cause for her atelectasis. I am convinced that early ambulation reduces pulmonary complications.

There was one postoperative hemorrhage in the entire series. It occurred on the fourteenth postoperative day following a vaginal hysterectomy. The patient had been seen in the office earlier on the same day. She was told that her condition was satisfactory and was asked to return in four weeks for subsequent examination. That evening I was called to the emergency room to see her. She was in shock and had apparently lost a large amount of blood. She stated that intercourse, about two hours before, was followed by a massive hemorrhage. The vagina was packed and 500 cc. of plasma and 1000 cc. of whole blood given. The packing was removed in the operating room and bleeding points looked for, but no active bleeding could be seen. She was kept in the hospital fourteen days. Her recovery was otherwise normal.

DISCUSSION

The disadvantages attributed to the total removal of the uterus have been increased mortality rate, prolapse of the vaginal vault, shortening of the vagina, and frequent injury to the ureter and bladder. Actually, these objections are not valid. As Masson has stated, they were copied from one paper to another and from one textbook to another until they were accepted as facts.

The mortality rate need not be higher than in the subtotal operation as proved by a large volume of statistics. In the present series of cases, the low mortality rate discredits the theory that the total operation carries a high rate.

The vagina need not be shortened if technical care is taken to remove no more than the cervix from the vaginal vault. It is unnecessary to place large clamps below the cervix before amputating the uterus. This method, which is not by any means a universal technique, may shorten the vagina. If the vagina is entered through the anterior or posterior cul-de-sac close to the cervical os, there is no conceivable reason why the vagina should be shortened. Actually, in the above series of cases, the vagina has not been shortened in any case except where radical hysterectomy was performed for carcinoma of the uterine fundus. In this group, a relatively large cuff of vaginal mucosa was purposely taken to prevent recurrence of endometrial carcinoma in the adjacent vaginal wall.

Total hysterectomy carefully done should leave adequate support for the vaginal vault. It is much easier to support the vault in a total than in a subtotal hysterectomy. In the latter case it is surprisingly difficult to support the cervical stump, and it will be noticed postoperatively that the cervix frequently hangs free in the vagina and is definitely predisposed to easy prolapse. By contrast, in the total operation the utero-sacral, cardinal, and round ligaments are incorporated into the angle of the vagina. This is a natural place for vaginal vault support. Incorporating the ligaments here gives a satisfactory result.

The ureter and bladder will be injured in a few instances by nearly all pelvic surgeons if a sufficient volume of surgery is performed and enough pathology encountered. This incidence will not be high, and if careful anatomical dissection is carried out, any injury that may occur can usually be repaired.

A technique most commonly used in hysterectomy, and to my mind prone to greatest liability of injury to the bladder and ureters, is the placement of multiple clamps along the side of the uterus. The peritoneal folds of the broad ligament are kept closed. This makes it exceedingly difficult to mobilize freely the cervix, ureter, and bladder. This technique will most certainly produce the greatest number of bladder and ureteral injuries. An open dissection of the broad ligament makes the operation easier and safer.

In a rather extensive review of the literature, almost all papers discussing the more general adoption of total hysterectomy warn that the operation can be very difficult, if not fully understood, and that training and experience in pelvic surgery are essential. Norman Miller, TeLinde and Holden report an increasing incidence of vesico-vaginal fistulae in their clinics, following total hysterectomy done elsewhere. These operations have been performed throughout the country and sent to these larger clinics for re-

pair. Foss and Babcock advocate total hysterectomy for the specialist but subtotal hysterectomy for the occasional operator. This thought-provoking paper is well worth reading, but I question seriously this approach to the problem. The patient should have the operation she needs, not the operation that the surgeon can perform. If a man who does pelvic surgery does not feel capable of doing a total hysterectomy, he should get enough training to enable him to perform the operation with confidence. The technique is easy and can be readily learned. I am convinced that in almost all instances the patient is infinitely better off with a total hysterectomy when hysterectomy is indicated.

CONCLUSIONS

1. Two hundred fifty-three cases of total hysterectomy are presented with a mortality of 0 per cent.

2. Four cases of carcinoma of the cervix were discovered histologically in a routine postoperative examination of all cervixes. In these four instances the hysterectomy was performed for benign disease of the uterine fundus.

3. The operative mortality of total hysterectomy in this series is lower than the incidence of carcinoma of the cervical stump.

4. Frequent injury to the ureter and bladder will not occur if the peritoneal folds of the broad ligament are incised freely, the bladder mobilized, and if the surgeon visualizes what is in the grasp of each hemostat.

5. The vagina will not be shortened if an anatomical dissection is carried out and if no more than the cervix is excised.

6. The vaginal vault will not prolapse if the round, utero-sacral and cardinal ligaments are incorporated into the angle of the vaginal cuff under normal tension.

7. With training and experience, a surgeon can develop a technique in which total hysterectomy can be performed as safely as the subtotal operation and with a negligible mortality rate.

8. If the cervix is removed, it cannot become infected, degenerate, prolapse or become malignant.

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Short Wave Diathermy Treatment of Sulfonamide-Renal-Block

BERT C. WILEY, M. D.

SHORT wave diathermy has been used for sulfonamide-renal-block at the Miami Valley Hospital, Dayton, Ohio, since 1941. Seven consecutive cases have shown such marked relief from anuria or oliguria that they warrant this report.

This treatment was apparently begun at about the same time by Rogan, who, in June, 1942, reported its use in a single case.¹

The pathology involved has been concisely stated by Callomon and by Prien: "The nephrotoxic properties of sulfonamides are due to the mechanical effect of the insoluble drug precipitate which irritates and finally destroys the lining epithelium of the tubules by pressure necrosis and simultaneously obstructs the renal passages."²

"Sulfonamide crystals first form in the convoluted tubules, where re-absorption of water occurs. Sedimentation of these suspended crystals occurs in the terminal portions of, the collecting tubules and in the renal calix. Proximity of crystals here results in aggregation and formation of concretions that obstruct the terminal portions of the collecting tubules. This process progresses in a retrograde manner up the collecting tubules."³

Barnes and Kawarchi⁴ state: "The chief factors influencing the precipitation of sulfonamide crystals and the formation of sulfonamide concretions are as follows: (1) concentration of drug in the urine, (2) degree of acetylation of the drug, (3) urinary stasis, (4) pH of the urine, (5) temperature of the urine."

Currently, good practice attempts to prevent such sulfonamide-renal-blocks by: (1) keeping the daily urine output above 1,200 cc., and (2) by administering enough alkali to keep the urine pH 7.5 or above.⁵

When preventive measures fail, currently recommended treatment includes:

1. Sodium bicarbonate per orum, intravenously, and if necessary per rectum, to produce systemic alkalization and dissolve the crystals; saline (according to blood chloride); rest; and 5 per cent glucose.
2. Massage of the renal tract.⁶
3. Cystoscopy and repeated pelvic lavage with warm 10 per cent sodium bicarbonate to attempt to dissolve the crystals in the pelves and ureters.⁵
4. Renal decapsulation.^{5, 6}

Submitted March 9, 1948.

The Author

● Dr. Wiley, Dayton, Ohio, is a graduate of Ohio State University College of Medicine, Columbus, 1943; member, American Congress of Physical Medicine; and director, Department of Physical Medicine, the Miami Valley Hospital.

In contrast to these operative procedures, the short wave diathermy treatment is:

- A. Very simple since it
 1. Can be given without extensive preparation of the patient (time, medication, or movement).
 2. Does not interfere with other more conservative measures (fluids, electrolytes).
- B. Very safe since it
 1. Does not increase the morbidity of the patient.
 2. Does not add further trauma to the urinary tract (as results from pelvic lavage).
- C. Very effective, since it
 1. Markedly improves the urinary flow, usually within three to four hours.
 2. Usually needs to be given only once, and seldom more than three to four times.
 3. Has never failed to work on a case of sulfa-induced renal-block upon which this therapy has been used by the Physical Medicine Department of Miami Valley Hospital.

RATIONALE

The solubility of the sulfonamides and their acetylated compounds rises rapidly with moderate increases in the temperature of their menstrum,⁴ just as do practically all water-soluble compounds.

The "deep" heat of short wave diathermy raises the temperature of the sulfonamide crystals in the kidney and the fluids in contact with those crystals. This heat dissolves their surfaces to a sufficient depth to allow the resulting smaller crystals to pass on down the tubules, and so relieve the block to the urine passage. (These smaller crystals probably abrade the lining

TABLE NUMBER 1

Patient	Age	Sex	Original Condition For Which Sulfonamide Used	Fluids Per Day In cc.	Sodium Bicarbonate P. O.	Time Sulfonamide Given Before Definite Oliguria	Time Sulfonamide Stopped Before Short Wave	Duration Of Oliguria Before Short Wave	Time After Short Wave To Appreciable Urine Output	No. of Short Wave Treat.	Significant Laboratory Findings.
BH 17	F		Epidemic Meningitis	2040	Yes	28½ hrs.	8¾ hrs.	20 hrs.	Time 11¾ hrs. Next d.	once	20.8 mg. % blood
MF 50	F		Rheumatic State	1350	Yes	4 days	19 hrs.	6 hrs.	2 hrs. 2nd d. Cont. Satis.	3 times bid	Prior to block sulfa crystals in urine; 5.5 mg. % blood
SJ 62	F		Not Known	3350	Yes	Indefinite No. of Days	3½ days	0 for 3 d. 190cc. total during 12 hrs. before SW	7 hrs. 2nd d.	5 times daily	Cystoscopic Exam: Crystals in bladder and ureteral orifices. Alb. 4+; N.P.N. 60mg. RBC loaded.
JR 38	F		Pneumonia	4330	Yes	3 days	4 hrs. (Not stopped)	Catheterized 1st day 200cc. next d. 500cc.	6½ hrs 12 hrs. 2nd d.	once	9.1 mg. % blood on second day after SW
PR 39	M		Pneumonia	3080	Yes	5 days	37 hrs.	17 hrs.	1 hr. 2nd d.	Repeated once in 12 hrs.	No significant laboratory findings.
HG 8	F		Meningo-Meningitis	2150	No	5 hrs.	22 hrs.	31 hrs.	½ hr. 7½ hrs. 2nd d.	once	Blood level at 25 mg. %
RC 38	M		Otitis Media	3360	Yes	4 days	4 days	62 hrs.	5½ hrs. 2nd d.	once	Blood level .4 mg. on day of Diathermy

epithelium less than the larger crystals that are forced through by hypertonic intravenous infusions.) After the "block" is once broken, the solvent action of the fresh, dilute warm urine washing the surfaces of the dialodged crystals further reduces their size. Thus, the crystals are often entirely dissolved by the time they are voided. Therefore, many cases of sulfonamide-renal-block released by diathermy do not reveal sulfonamide crystals in a routine simple test of voided urine. The crystals, however, will appear if the specimen is concentrated by evaporation, or if its pH is lowered.

RESULTS

A. The results of seven consecutive cases of sulfonamide-renal-block in which short wave diathermy was used over the posterior renal area are given in Table Number 1. This evidence shows that short wave diathermy apparently hastened, if not actually caused the return of satisfactory urine elimination. Although sodium bicarbonate was used in every case but one, and the daily fluid intake varied from 1350 cc. to 4330 cc., the oliguria or anuria had persisted an average of 34 hours before the short wave diathermy was employed. A significant volume of urine was voluntarily voided an average of 5.9 hours after its use. An average of 2218 cc. was voluntarily voided the next day after diathermy, indicating that a relatively free urinary passage had been achieved.

B. Oliguria and even anuria may be caused by simple ureteral spasm. Ureteral spasm may occur after some surgical procedures, ureteral catheterization, the passage of calculi, or the instillation of an irritating substance used in retrograde pyelograms. In these cases short wave diathermy is extremely effective in relaxing the spasm and restoring the normal flow of urine quickly. Our latest case of this type is typical: A 38-year-old white male was admitted for cholecystectomy, but simple X-rays of the abdomen did not adequately differentiate gall stones from kidney stones. Number 6 ureteral catheters were used during a retrograde pyelogram study between 9:15 and 9:55 a. m. By 1 p. m. the patient complained of severe pain in his lower abdomen radiating to his low back. At 5:00 p. m. he last voided 25 cc., after having drunk 1120 cc. of fluids that day. The following day he drank 640 cc., received 500 cc. of 5 per cent glucose in distilled water intravenously, and had two injections of 50 cc. of 50 per cent glucose in distilled water intravenously. He was catheterized three different times without avail. On the next day he was given 2,000 cc. of fluid parenterally without effect. At 1:45 p. m. (approximately 45 hours after the last voiding) he was given thirty minutes of short wave diathermy across his posterior kidney

area, and thereafter voluntarily voided as follows:

100 cc. Concentrated	at 3:15 p. m.
200 cc.	at 4:45 p. m.
110 cc.	at 6:15 p. m.
200 cc. Clear Amber	at 8:30 p. m.

This response to short wave diathermy is in line with its well-known function of relaxing tonic contractions of muscle (both smooth and skeletal).

CONTRAINDICATIONS

Diathermy is considered to be contraindicated in all cases of non-sulfonamide-induced nephritis. When tried in these cases, it either produces no significant improvement, or causes a definite decrease in the urinary output. The passive hyperemia induced in the electric field probably produces this result. Since the kidney is already congested by cloudy swelling, etc., this diathermy-induced passive hyperemia within an already tense capsule tends to compress the weakest-walled element first—the glomerular capillaries—and thereby prevents the excretion of urine at its source.

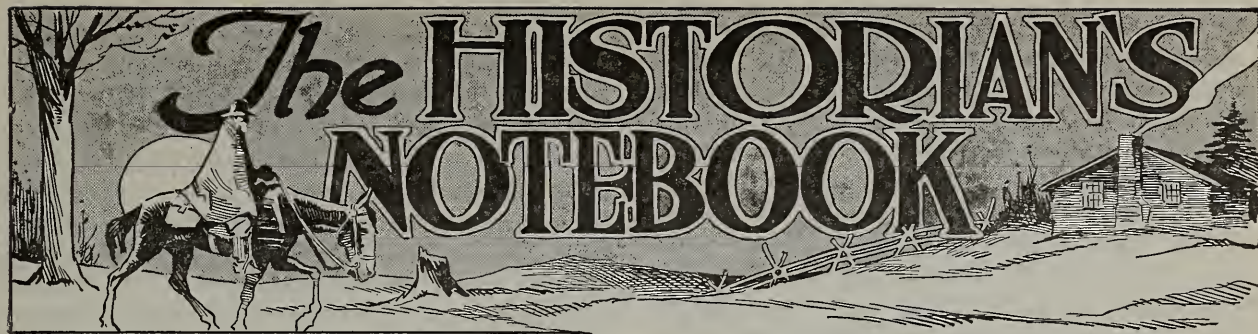
SUMMARY

The rationale and results of the use of short wave diathermy over the kidney area of patients suffering from sulfonamide-renal-block, indicate that this is an extremely worth-while method of treating this usually serious complication. A typical case is presented of the use of diathermy to alleviate ureteral spasm. The use of short wave diathermy is contraindicated over kidneys damaged by non-sulfonamide-induced nephritis.

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The kaleidoscopic nature of tuberculosis, the sometimes bizarre effect of streptomycin upon it, and the fact that the drug at best merely supplements and does not replace accepted methods of treatment require that its use be confined to institutions for the treatment of the disease. The patient must have sanatorium care and all of the supportive treatment that tuberculosis has always required, along with collapse procedures and other necessary surgical methods.—Henry Stuart Willis, M.D., North Carolina M. J., Nov., 1947.



The Family Life of Rufus W. Stearns—A Pioneer Ohio Physician. Part I

DON M. STEARNS

DR. R. W. STEARNS was born June 21, 1809, at Rutland, Meigs County, Ohio. His father, Rev. Asa Stearns, was a Free Will Baptist circuit riding minister who received part of his pay in barrels of whiskey. Rufus Stearns was determined to equip himself to be of benefit to his fellowmen, and since a circuit riding minister did not receive a plethora of money he had to be very energetic and frugal to save the necessary money to attend medical school.

He entered the Medical College of Ohio, located at Cincinnati, in the fall of 1831. While there he took the following subjects: institutes of medicine and clinical practice, anatomy and practical anatomy, the theory and practice of medicine, chemistry and pharmacy, materia medica, botany, obstetrics and diseases of women and children, and surgery. He was a member of the class to whom Dr. Daniel Drake dedicated his *"Practical Essays on Medical Education and the Medical Profession in the United States."* For these courses his tuition was \$160 plus three dollars for his diploma.

On April 20, 1832, he was licensed to practice all branches of medicine and surgery by the First Medical District of Ohio. He went to MacArthur, Ohio, to begin practice, but in the fall of 1832 moved to the recently settled town of St. Marys, Ohio. This little community of less than one hundred people was a typical pioneer town which had been carved from the wilderness and was yet surrounded by virgin forests which presented all the perils indicative of the American frontier. Dr. Stearns, who was the first resident doctor of that town, remained in the vicinity of St. Marys until his death in 1877. He contributed immeasurable good to the community by being an excellent doctor, a devoted

father, and a person willing to sacrifice much time to further the interests of the community of which he was a very important part.

His ability as an excellent physician and surgeon soon became known throughout most of northwest Ohio. By horseback with saddle-bags he administered to the sick over a radius of forty miles. He had to contend with the various diseases caused by the swamp and unhealthful conditions that were concurrent with the building of the Miami-Erie canal, plus the other numerous diseases such as the agger, chills, cholera, diphtheria, smallpox, etc. During one diphtheria epidemic he was successful in not losing a single case, and his throat prescription is still used effectively by members of the family. In one smallpox epidemic he treated some 300 cases, and in a cholera siege of 1855-56, he labored tirelessly until he was stricken by the disease and had to be taken to his farm to escape death.

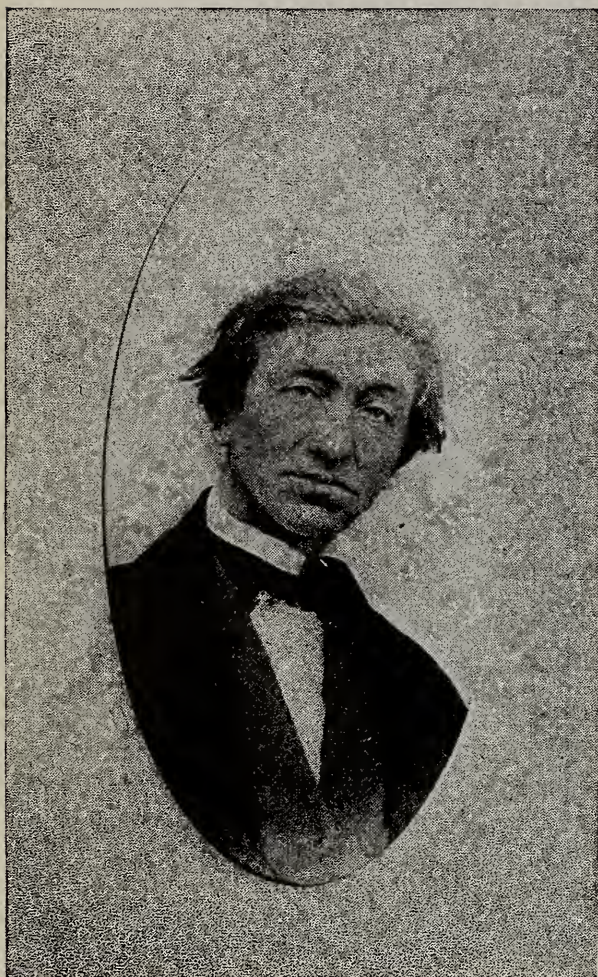
But there was always a lighter side to the life of even a pioneer doctor. In 1855, with another doctor, he established the first apothecary shop in the town. They bought most of their herbs and medicinal roots from young boys, and then would store them in the backroom. Some of the boys would steal them from the room and sell them over as often as three times, thus increasing their investment to envious heights.

The kindnesses he rendered in fulfilling his position as a doctor gave him a reputation that still lives in the memories of many octogenarians, and will be known as long as local history is read.

Not only was he an able physician and surgeon, but his family life was one to be emulated. His marital history begins November 3, 1835, when he married Sarah Ann Carpenter, a school teacher at Marietta, Ohio. This new couple started life in a log house at St. Marys, but after two years moved to a frame house. By

Excerpts from a Thesis for Honors by Don M. Stearns, Lima, Ohio, Otterbein College, Class of 1948, and great grandson of Dr. R. W. Stearns. Brief description of his family life prepared for *The Ohio State Medical Journal*.

1838 they had a very comfortable home, and also owned a large farm on the Celina-St. Marys road. In this new home Drs. Stearns and Medbury had their office, and there were seven additional rooms, all with fireplaces, and a living room with a very large fireplace. To this home Dr. Stearns brought the first cook stove used in St. Marys, and the first pie pans seen there. These items were shipped from Cincinnati by packet on the Miami-Erie canal, which had been completed in 1845. There was a large yard beside the house, and at the corner of Spring and Front Streets



was a hog pen, while across the St. Marys River was a barn for horses and cattle. The pasture lots were south of the home where the children would gather hazel nuts and wild plums after turning the stock loose.

In 1855 he traded some land that he owned on the reservoir for another home in St. Marys. The south part of this newly acquired home had been built in 1840, and the north part in 1848. On the south, with a front of glass doors, was the office of Dr. Stearns, and behind it were personal quarters for his mother, although she boarded with the rest of the family. The upstairs of the south section had been at one time a printers' office, and later a schoolroom where

one of his daughters had been a pupil of Miss Ward, but it now served as a sleeping apartment for the family. In the north section they had the "parlour" and the parlour bedroom.

Since there were six fires to be fed it required great efforts by his sons to haul wood enough from the farm to keep the house warm. Every room had a wood box which was covered with wallpaper and trimmed with border. Dr. Stearns would arise very early every morning and start the fires, then he would call the children often as early as four-thirty to prepare their lessons. He only slept four hours every night, for his medical practice, community activities and family used the other twenty.

The floors of this home were covered with rag carpets, although in the earlier days ingrain had been used for the parlor. On the floor under the tables were stacks of books and pictures. The custom of hanging pictures on walls did not appear until later, and then pictures were hung on the wall with cords, tassels, and still later with throws of needlework or painted cloth.

After the dishes had been washed the plates were turned over on the table with the knife and fork placed under them, but the spoon was placed in a "spoon holder." The salt, pepper, and pepper sauce were put on a castor, and there was a large covered dish for butter, and also some sauce tureens. The saucers were almost as large as the cups, and it was customary to pour coffee from the cup into the saucer, then drink the coffee from there. The cup was afterwards put on a cup plate so it wouldn't soil the table cloth.

Dr. Stearns did the marketing for the family, and always purchased the supplies in wholesale lots. Barrels of sugar, crackers, pickled pork, corned beef, mackerel, cider vinegar, and other such products were on hand all the time. Before the time of canning, fruits were dried; two of the most common being peaches and apples. Later tin cans appeared, and he would do the soldering for Sarah when she canned fruits and vegetables. (This was before sealing wax for that purpose had been invented.) Pickles and kraut were put in brine, dried corn and at least thirty head of cabbage were stored, and an abundance of preserves was readied for the winter. Coffee came unground and had to be roasted in the oven before use. Hops, which are used to make yeast, were picked, dried, and stored so that bread could be made.

Two large barrels were used to collect ashes for soap making. The lye from these ashes, and the fat from meat rinds would make soap that was used for everything except bathing. A barrel of soft soap was kept in the basement, and a pitcher of it was used in the kitchen. It was also necessary to have candle dips to make both sperm and tallow candles.

In the evenings candy was made from maple

syrup and New Orleans molasses. Before the time of stoves these ingredients were placed in a big kettle that stood over the fireplace. Often parched corn with homemade butter also provided a delightful repast in the evening.

For many years the good dresses for the children were made of merino or delain, while the play and school dresses were made of calico or gingham. Pantelletes were worn that buttoned onto the top drawers and extended below the knees. The summer underwear was made of muslin, but the winter cold necessitated the use of flannel. Boots and shoes for the family were made by a local cobbler.

Dr. Stearns' farm, which was located on the north bank of the reservoir, contained 234 acres at the time of his death. The farmhouse, a large structure made of logs and weatherboarded,

many years, and there was a market for ducks and frogs also. Large ducks brought twenty-five cents, small ones fifteen, while frogs sold for twenty-five cents a dozen, if they were large enough. After around 1860 one usually had to go north to Paulding County to obtain wild turkeys and deer, for by that time these animals were going to more remote sections.

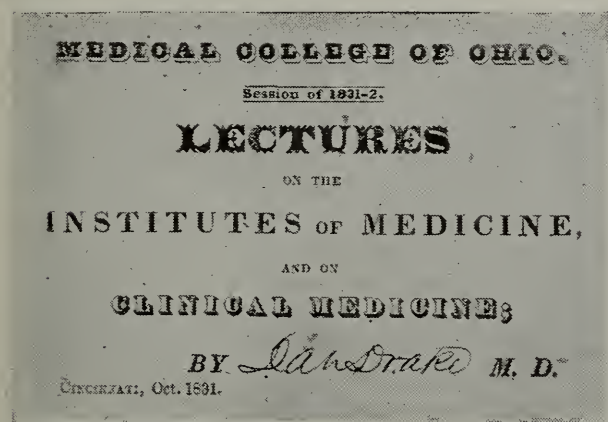
A story is told of the hunting skill of Dr. Stearns. It seems he was hunting along the edge of the reservoir one evening with hopes of getting a few turkeys for the Thanksgiving dinner, when suddenly a flock flew up. He shot two and had about given up hope of getting any more in the dusk, when he found that the turkeys had lit upon the water and were unable to take off. He got his boat and fished out twenty turkeys, but allowed seventeen to return to the woods.

He had a very fine pair of saddle horses and also a pair of oxen. There was a large carriage for the family, and a two seated sleigh for winter. The sleighbells with their unusually clear tone would herald the arrival of Dr. Stearns over the frozen roads. Most of the time he traveled horseback, but he had a two wheeled gig that he occasionally used.

This busy doctor also took time to become one of the best fruit growers in this part of Ohio. The quality of his fruit was excellent, and the quantity was great enough to ship 250 barrels by packet to Cincinnati and elsewhere. In his orchard were 700 peach trees, 1100 plum trees, 300 cherry trees, and numerous trees of pears, apricots, etc. There were two large apple orchards, one on either side of the road, and some of the varieties of apples produced were: Russets, Vandivars, Winesaps, Northern Spy, Bellflower, Rambos, jonquils, codlins (an extra fine cooking apple), Maiden Blush, Rome Beauties, and one row of white sweet apples. Cherry trees were used for fence posts throughout the farm. The plum orchard was between the house and the barn, and the rest of the orchard extended westward.

From the farm house to the edge of the reservoir was a vineyard, and also rows and rows of currants, gooseberries, raspberries, strawberries, and blackberries. Fresh preserves and fresh homemade bread were rare delights this time of the year.

The first cider mill in this country was built by Dr. Stearns. It attracted farmers for miles around who would line the barnyard with their wagons of apples to be ground into cider. After they had been taken care of an all night session was required to produce some unsurpassable apple butter. Four barrels of sweet apple cider were boiled down to one barrel, and this quantity was then thickened with rambos and sweet apples.



was on a knoll about 100 yards from the water. There was a long front porch, and inside was an immense fireplace. The cooking was done with a dutch oven and a reflector, the latter was used mostly for baking biscuits and bread. The lips of the dutch oven would hold hot coals that were poured over it, and effect a more uniform temperature than could be obtained from an open fireplace.

There was a large barn also built of logs, that was between the house and the reservoir. Behind the house was a building where tools and equipment were stored, and behind it was the ice house. Here chunks of ice that had been cut from the lake in the winter were packed with sawdust, and thus gave refrigeration for the summer.

After several unsuccessful attempts to find good water near the house they finally dug a well across the road, which was about two hundred feet, that yielded good water. The horses and cattle were watered at the reservoir.

In these days much of the food consisted of wild game, which, due to the vegetation of the reservoir, was plentiful. Great flocks of ducks and geese, large coveys of quail, rabbits, fish and frogs gave a variety to the meals. A carload of fish was shipped from the lake daily for

The mixture was constantly stirred to keep it from burning, and by morning a winter's supply of apple butter was ready.

Across the road was the sugar camp, where maple sap was boiled down into maple sugar and maple syrup after it had been collected from the hollowed chunks of wood that served as pails.

At butchering time as many as fifteen hogs and three beeves were killed to supply the needs of the family. With all the enterprises of this busy man consuming so much of his time, he still made room for God. On Saturday all tasks were done, such as blackening the shoes, cooking and baking. Then Sunday was observed as the Holy Day in all respects. The family went to church together, and put their burdens aside for the entire day. Every morning they had devotions where they would give thanks to the Heavenly Father for all that He had done, and in turn ask for support to continue to make from this wilderness the great country it is today.

Little remains of the old farm house. A dead locust tree marks the spot where the house once stood. A few shrubs, an old pump, some boards, and a golf course take in part of the farm. Civilization in its evolution has destroyed the visual landmarks of this country doctor's home, but those who remember history pause with respect when passing the old dead locust tree, and for a moment the mind attempts to visualize the homestead that was a part of the development of Celina and St. Marys, and through whose portals a noble man once walked.

To Be Continued

First Incubator Baby

Dr. L. R. Culbertson, Zanesville, Ohio, testifies to the authenticity of the following story as published in the *Zanesville Signal*, July 6, 1948.

A prominent Zanesville woman, now 84 years old, is said to be one of the first "incubator babies" ever to survive. We can't give the name; in fact, our informant would not tell us, but he did supply some interesting details.

The baby, born prematurely, weighed only two pounds and four ounces at birth, which meant—in those Civil war days—that survival was considered out of the question.

But Dr. Charles C. Hildreth, one of Zanesville's best medical men in the nineteenth century, had ideas of his own. He had the baby placed in a carefully insulated oven, where an even temperature was maintained until the infant became strong enough to survive under normal conditions.

She did survive and—as we said before—is living in Zanesville today. Dr. Hildreth's oven technique preceded the modern baby incubator by sixty years.

Professor Charles A. Lee

I shall never forget Charles A. Lee, Professor of Materia Medica and Medical Jurisprudence; how, in his simple and trite manner, he used to describe and inculcate the habitat, the history, the properties and the *modus operandi* of the several articles of the *Materia Medica*. I recollect very distinctly, when telling, at a certain time, the particular effect a certain article would have upon the abdomen and its organs, he used the vulgar term belly, which wonderfully excited the risibilities of the class, whereupon he said, apparently not at all discommoded: "You need not laugh, gentlemen, it is always best, when we wish to make ourselves understood, to use common words—and I am sure the word 'belly' you can all understand!"

Then again, when descanting in a general way, at a particular time, he said some *insane* persons have many *sane* qualities which prevented persons not familiar with them from recognizing them as being *non compos mentis*. "For instance, gentlemen, you almost daily meet some of the inmates of the Insane Asylum upon the streets, and really you might make the mistake and take them for medical students!"

Those occurrences mentioned are but a few of the very many characteristics that occurred and might be named with interest, relative to the truly great and noble Professor Charles A. Lee.—Reminiscences Bearing Upon the Faculty and Students of Starling Medical College during the Session of 1853-54. J. S. Haldeman, M.D., Zanesville. Delivered March 9, 1888.

Skin Diseases

I now present you this case of Urticaria, named from the resemblance of the eruption to that produced by the nettle. By rubbing this patch, the congestion and lateral pressure is produced, and you see the white spot appear. This disease is produced from irritants upon the skin, and by certain kinds of food. Doubtless nervous irritation is added in some cases, as in the "hives" of children while teething. Quinine will produce Urticaria in some people, salt fish and cheese in others.—*The Ohio Medical Recorder*, Volume 1, Number 7, December, 1876.

* * *

Bismuth in Eczema, Etc.—An ointment containing about a drachm of bismuth, subnit. to the ounce, relieves greatly the itching and pain of eczema and many other forms of skin disease, and in many cases suffices for a permanent cure.—P.E.B., *The Ohio Medical Recorder*, Volume 1, Number 8, January, 1877.

* * *

Lotion for Urticaria—Chloroform, 10 parts; oil of sweet almonds, 30 parts. Use several times daily.—*New Remedies. The Ohio Medical Recorder*, Volume 1, Number 8, January, 1877.

A. M. A. House of Delegates . . .

At Chicago Session Takes Action on Many Current Problems Facing Present and Future Course of Medical Practice and Public Health

FOLLOWING is a summary of some of the actions taken by the House of Delegates of the American Medical Association at the Annual Session held in Chicago, June 21-25.

The entire proceedings of the House of Delegates were published in detail in the July 3, July 10, and July 17 issues of the *J. A. M. A.*

CITATION

Amended the By-Laws directing that the Board of Trustees create and establish an award to be known as the Citation for Distinguished Service to be presented to persons not of the medical profession and who have by their cooperation and aid in the advancement of medical science, medical education or medical care contributed to the advancement of the ideals of American Medicine.

Approved a resolution to the effect that the American Medical Association take steps to cooperate with the American Cancer Society and other agencies engaged in this activity for the purpose of formulating standards of procedure and conduct in the operation of cancer detection and diagnostic centers.

Instructed the Board of Trustees to bring in a report at the Interim Session on reported exploitation of professional medical services by certain hospitals. A resolution introduced on this subject specifically mentioned exploitation in the fields of radiology, pathology, and anesthesiology.

Approved substitution for a resolution on the same subject, the following statement of the Council on Medical Education: "The Council has gone on record favoring an intensive effort to secure voluntary support for medical education. Therefore, the Council is opposed to the plan of the American Academy of Pediatrics. The Council feels that it is extremely unwise for one specialty in medicine to seek Federal support before medicine and medical education in general have approved this principle."

CHILDREN'S BUREAU POLICY

Resolved to enter a formal protest against the policy of the U. S. Children's Bureau whereby only surgeons who are certified by the American Board of Orthopedic Surgery, or are eligible for such certification, should be approved by a state agency for surgical services for children suffering from orthopedic conditions. The protest recommends that the administration's policy be

liberalized to permit participation on a state level by all physicians qualified.

Approved a resolution recommending to the appropriate government officials that physicians engaged in examinations of candidates for Selective Service or Universal Military Training be paid for their work.

Approved a resolution to the effect that the American Medical Association should withdraw and withhold its consent and approval from any legislation pending or proposed unless such legislation embodies the repeatedly expressed principle that Federal grants-in-aid for medical and health services should be made available only to those states which can demonstrate a definite need for Federal financial assistance.

BLOOD BANK

Unanimously adopted the report of the Committee on Miscellaneous Business dealing with the Red Cross Blood Bank, a summary of which follows:

The committee, realizing the possibility of a national emergency requiring large amounts of blood in the treatment of civilian and military casualties and the unique position of the American Red Cross in disaster relief, expressed its opinion that no change should be made at the time in the approval in principle of the participation of the American Red Cross in the national blood program voted at the Interim Session in January, 1948.

The committee called attention, however, to the fact that long before the Red Cross entered the field many local blood banks operated independently and successfully, and expressed the opinion that it would be "unwise and disastrous" to disturb these local units.

The following points were construed as "approval in principle":

"First, local control must be by the county medical society.

"Second, the local medical society should be the initial contact in the contemplation of inauguration of a new blood bank.

"Third, no publicity nor news releases shall be released except by mutual consent of the local county medical society and the local chapter of the American Red Cross.

"Fourth, difference of opinion in establishment or operation of a blood bank in either administrative or technical detail shall be arbitrated at the state levels by joint committees from the state medical society and the American Red Cross."

It was recommended that the committee of the American Medical Association be enlarged to nine members with definite instructions to meet at stated intervals at the call

of either the chairman of the committee or that of the Red Cross.

"Your reference committee feels that any provision of free medical service or supply to everyone without regard to ability to pay is in opposition to the principle that it is the responsibility of an individual to assume the obligations of medical expense just as he does for other living expense. Your reference committee deplors the use of the term 'free blood' in the publicity of the American Red Cross."

Approved a recommendation on advancement of rank of surgeons general of Army, Navy, and Air Corps.

GENERAL PRACTITIONER

Approved a system of progressive steps in selecting the outstanding general practitioner of the year. Each county society is urged to select its candidate for the award. Each state association will in turn select from the candidates of the county societies its representative for the award. The Board of Trustees will select from the candidates of each state three names which will be submitted to the House of Delegates for its choice of one. State associations are authorized to confer suitable awards on their respective outstanding general practitioners.

Approved in part a resolution entered in executive session advocating expansion of the Washington Office of the American Medical Association.

Approved a resolution requesting the Veterans Administration to put into uniform practice a free choice regulation for medical and hospital treatment in service-connected cases.

Approved with slight changes and additions the report of the Council on National Emergency Medical Service as printed in the Handbook. Among additions to the report was a request that each county society and state association organize a committee directly responsible for national emergency medical service within its organization. A resolution was approved offering the full services of the A. M. A. to the armed forces in planning orderly methods of selection and induction of medical officers for military and civilian service in case of need, and ordering a survey of all physicians in the nation to facilitate such planning.

Directed the Board of Trustees to nominate among members of the Council on Medical Education and Hospitals one private practitioner, not a faculty member of a medical school nor on the staff of a hospital associated with a medical school.

ALLOCATION OF INTERNS

Approved a resolution to the effect that in order to preserve the general practice of medicine, the American Medical Association institute a program to allocate the number of interns of all

approved hospitals on an equal basis according to yearly admissions, and referred the matter to the Council on Medical Education and Hospitals for consideration.

Approved in substance the report of the Committee to Study Conditions of General Practice. Among the recommendations of the committee were the following:

That every general hospital be organized so as to give general practitioners adequate staff privileges and representations.

That the Council on Medical Education and Hospitals proceed with the development of a program to utilize smaller hospitals not directly associated with medical schools for training of general practitioners.

The committee expressed opinion that the hospital staff should be the sole deciding body as to who may practice medicine in the hospital either as a staff member or as having hospital privileges, since the certifying boards pass only on the ability of a man to perform work in his specialty.

"The Committee also believes that the general practitioner does not show adequate interest in organized medicine, local, state or national, and that he should be urged to participate in all activities of organized medicine, both scientific and organizational."

RURAL MEDICINE

Approved a progress report of the Committee on Rural Medical Service. It was reported that in at least 19 states health councils on the state and community level have been organized under the stimulus and guidance of the medical profession. The Board of Trustees has authorized this committee to engage a field secretary.

Approved the report of the Committee on Intern Placements. The report requires the Council on Medical Education and Hospitals to carry out the following recommendations:

That hospitals and medical schools which do not cooperate with the Plan For Uniform Intern Placement be reported to the Council on Medical Education and Hospitals for investigation and appropriate action;

That, in the interest of promoting general practice and better to prepare a physician to choose a specialty, all specialty boards require at least one year of approved rotating internship before allowing a physician to start his specialty training;

That an approved rotating internship shall be of one or two years' duration; should include an educational training program in medicine, both organic and functional, obstetrics, pediatrics and surgery with especial emphasis on diagnosis under the supervision of a qualified educational director of interns;

That hospitals at present approved for internship should be reappraised on the basis of their educational program for interns;

That any hospital which does not provide an adequate educational training program for interns may be approved for general residencies for graduates who have completed an approved, rotating internship of at least one year.

Physicians and the P.T.A. . . .

Inclusion of "Health" in Four-Point Program of National Parents-Teachers Group Challenges Medical Profession; Objectives Summarized

CLOSE cooperation between the medical profession and other organizations taking a direct interest in improving the health of young and old, through educational programs and action projects to provide better health facilities, is quite apparent to all members of the medical profession who are practical enough to realize that good results will depend on united action and mutual agreement between the medical profession and the lay groups of the community.

Announcement by the National Congress of Parents and Teachers that "Health" is one of its specific points in its current Four-Point Program indicates the need for the closest working understanding between physicians, and P.T.A. groups in all communities.

JOB FOR COUNTY SOCIETIES

This is a question which deserves a prominent place on the "must business" docket of each County Medical Society in Ohio. The following summaries of the material which has been issued by the national P.T.A. to its local units offer many ideas and suggestions for local cooperative study and action.

Regarding its decision to include health in its Four-Point Program, the National Congress of Parents and Teachers comments as follows:

FOUR BASIC PROJECTS

The war showed us vividly enough the effects of our negligence in this department of life. Adequate health facilities are vital to the nation and must be set up speedily wherever they are lacking. Health cannot be slighted without disaster; if we are to have a generation of healthy minds they will have to be developed in healthy bodies.

1. Cooperate in every possible way with public health departments to intensify and expand present local health services and facilities and also to spread sound health information throughout the community.

2. Instill in students and parents an understanding of the modern changes that have taken place in the professions of nursing, dentistry, medicine, and other technical fields of health service; and point out to them the advantages of training for careers in the fields of health—not only to relieve personnel shortages but to gain personal satisfaction, economic and social security, and a sense of service to mankind.

3. Study and evaluate community provisions

for maternal and infant care; prenatal clinics, hospital and nursing facilities, well-baby clinics, and the like; and, with the counsel of the local health officer or department, promote action to expand or augment whatever services are necessary to safeguard the physical and mental health of both children and adults.

4. Survey community provisions for the care and education of all exceptional children, including the physically handicapped, the mentally deficient, the emotionally troubled, and the gifted; work with appropriate agencies to give these children the special training they require to attain their best development; and act to secure necessary legislation to insure such provisions on a state-wide basis.

The P.T.A. is not content just to state the problem and the general principles. In a document outlining suggested actions which local units should take, it offers the following recommendations:

Evaluate community resources.

Find out from local health leaders what the P.T.A. can do to help raise health standards.

Appoint a committee to arrange for a series of talks by health leaders such as the local, county, or state health officer, the head of the medical or dental society, a prominent hospital administrator, and so on. Subjects for discussion might include the following:

In what ways can the P.T.A. spread sound information about the health needs of the community?

How can the P.T.A. help to improve and extend health services that will meet these needs?

What are the effects of malnutrition on the mental, physical, and emotional growth of children?

If qualified personnel is lacking, what volunteer assistance can the P.T.A. offer toward the advancement of the community child health program?

Ask the health committee to visit local health departments, hospitals, laboratories, X-ray clinics, or county medical and dental societies and report back to the association on what these agencies, institutions, or organizations are doing to improve health conditions in their respective areas.

Request that the health chairman make a list

of community health problems, and present them to the P.T.A. for discussion and action.

Help to recruit qualified professional personnel.

Plan forums, round tables, or panel discussions that will give parents and young people information about the opportunities open to persons trained in the field of health.

Invite professors of medicine, dental experts, head nurses, physical therapists, and health technicians to speak at P.T.A. meetings in order to explain recent changes that have taken place in the professions of nursing, dentistry, medicine, and engineering.

Plan to observe Public Health Nursing Week, which falls in April of each year. Get in touch with local or district nurses' associations and ask for their suggestions on how to help recruit more nurses.

Investigate the possibilities for setting up scholarships or student loans for young people with the inclination and the ability for a career in the field of health. Find out what scholarships in this field are already being offered.

Promote the health program in general.

Support all approved health legislation—local, county, state, and Federal—including measures providing for maternal and child welfare, appropriations for the survey and construction of hospitals, and provisions for other public health services.

Cooperate with school authorities on plans to include health instruction in the curriculum of every grade from kindergarten through high school. If the school has no qualified nurse on its staff, urge the school board to make provision for one, furnishing adequate facilities for her work, and for students' health examination.

Find out what is being done in the community, the county, and the state on behalf of exceptional children, and work through the proper channels to give them the care and education best suited to their needs.

Organize parent education classes to teach adults the importance of health services, the relation between physical and mental health, the necessity for early detection and treatment of defects, approved standards of nutrition, and other necessary information. Cooperate wholeheartedly in all state and national plans to promote the circulation and use of *National Parent-Teacher: The P.T.A. Magazine* in order that members may have access to the information on health contained in each issue.

Meet community needs.

Promote the Summer Round-Up of the Children, and encourage parents to see that remediable defects are corrected promptly. Bear in mind that the Round-Up can help develop fellowship among the parents of preschool children.

Impress upon parents the importance of im-

munizing and vaccinating children against communicable diseases, and offer assistance to the health department if needed.

Publicize the health facilities available to adults and children in the community, and encourage the full use of these services.

Cooperate with other community organizations in such projects as establishing a health council, a health center, a supervised playground, a recreation center, prenatal or other services if present services are not adequate.

Fishbein To Study Medical Practice in Britain

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, departed for London, July 30, to study various aspects of the new British National Health Act. He will confer with Aneurin Bevan, Minister of Health, and officials of the British Medical Association. Dr. Fishbein plans to meet with a group of general practitioners to study the effects of the new health act, which is a universal compulsory, tax-supported, and government administered program, costing an estimated \$720,000,000 during the first nine months.

Ohio Polio High in 1947

Ohio in 1947 had the largest number of cases of poliomyelitis of any state, but was fourth among states in the incidence per 100,000 population, according to *Public Health Reports*.

Ohio had 1,465 cases, New York 1,189, California 878, Illinois 852, and Michigan 653. Ohio was the only one of these states with large populations that had a relatively high rate. The highest incidence per 100,000 population occurred in Idaho where it was 72.1. In Delaware the rate was 39.2, in Rhode Island 18.9, in Ohio 18.8, and in Nebraska 15.4. The rate for the country as a whole was 7.4.

In the United States the number of reported cases of poliomyelitis in 1947 was smaller than for any year since 1942. Compared with 1946, there was a reduction amounting to almost 15,000 cases or 60 per cent.

American College of Physicians

The American College of Physicians will conduct its 30th Annual Session at New York, N. Y., March 28 through April 1, 1949. Dr. Franklin M. Hanger, Jr., of New York City is the Chairman for local arrangements and the program of Clinics and Panel Discussions. The President of the College, Dr. Walter W. Palmer, Director of The Public Health Research Institute of the City of New York, Inc., and Professor Emeritus, Columbia University College of Physicians and Surgeons, is in charge of the program of Morning Lectures and Afternoon General Sessions.

Fall Postgraduate Courses . . .

Association Sponsors Courses at Chillicothe, Lima, Mansfield;
Councilor Districts and Other Organizations Offer Programs

OHIO physicians will find a wide variety of postgraduate courses offered this fall in various sections of the State. These courses include three sponsored by the Ohio State Medical Association as well as several offered by Councilor Districts, county societies, specialty groups, and other organizations.

The three courses sponsored by the Ohio State Medical Association are as follows:

"New Advances in the Diagnosis and Treatment of Chest Diseases"; Elks Home, Chillicothe, Thursday, October 21, beginning at 2 p. m.

"Practical Cardiology"; American Legion Hall, Lima, Wednesday, October 27, beginning at 2 p. m.

"Practical Dermatology"; Mansfield-Leland Hotel, Mansfield, Wednesday, November 3, beginning at 1:30 p. m.

Following are other programs included in this roundup:

Second Councilor District Postgraduate Day, Springfield Country Club, Springfield, Wednesday, September 29, beginning at 1:30 p. m.

Joint program of the American Society of Anesthesiologists and the Ohio Society of Anesthesiologists, Hotel Commodore-Perry, Toledo, Friday and Saturday, October 1 and 2.

Northwestern Ohio Medical Society, Annual Meeting, Findlay College, Findlay, Tuesday, October 5.

Muskingum County Academy of Medicine, Special Program, Hotel Rogge, Zanesville, Thursday, October 7, beginning at noon, to which southeastern Ohio physicians are especially invited

Sixth Councilor District Postgraduate Assembly, Mayflower Hotel, Akron, Wednesday, October 13, beginning at 9 a. m.

CHILLICOTHE

Thursday, October 21 Elks Home

42 W. Second St.

"NEW ADVANCES IN THE DIAGNOSIS AND TREATMENT OF CHEST DISEASES"

Carl A. Wilzbach, M. D., Cincinnati, Chairman

John H. Skavlem, M. D., Cincinnati, Director of Seminar

(Time Schedule—Eastern Standard Time)

2:00 - 2:30 P. M. "Pathogenesis and Clinical Considerations."

JOHN H. SKAVLEM, M. D., Cincinnati; associate professor of medicine, University of Cincinnati College of Medicine; medical director, Hamilton County Tuberculosis Sanatorium.

2:30 - 3:00 P. M. "Laboratory Aids in the Diagnosis of Pulmonary Diseases."

- Emphasis on practical and valuable means of laboratory diagnosis.
- Fallacy of accepting negative direct smear sputum reports.
- Value of cultural studies and animal inoculations.
- What the general practitioner should know.

W. L. POTTS, M. D., Columbus; superintendent and medical director, Franklin County Tuberculosis Hospital; tuberculosis controller, Columbus and Franklin County; assistant professor of medicine, Ohio State University College of Medicine.

RECESS

3:15 - 4:00 P. M. "Chest Films."

- How to obtain them.
- What they show.
- How to see them.
- Films to illustrate the discussion.

D. W. HEUSINKVELD, M. D., Cincinnati; instructor in medicine, division of tuberculosis, University of Cincinnati College of Medicine; staff member, Dunham, Good Samaritan, and Bethesda Hospitals.

4:00 - 4:30 P. M. "Planning the Management of the Patient with Tuberculosis."

- What to tell the patient.
- What to tell his family.
- Home vs. sanatorium care.
- Household hygiene.
- Rehabilitation.

JOSEPH B. STOCKLEN, M. D., Cleveland; assistant clinical professor of medicine and preventive medicine, Western Reserve University School of Medicine; visiting physician, Sunny Acres Hospital, and Lowman Pavilion City Hospital; controller of tuberculosis for Cuyahoga County.

4:30 - 5:00 P. M. "Developments in Chest Surgery."

- Slides, drawings and photographs showing recent advances in surgical treatment of chest diseases.
- Practical application of surgery.
- Breathing difficulties, abnormalities of the upper gastro-intestinal tract and cardiovascular anomalies of new born.
- Cancer of the esophagus and upper gastro-intestinal tract, with presentation of cases.
- Pulmonary tuberculosis summarized pointing out that it automatically becomes a surgical disease once bed rest is shown to be inadequate; removal of lobes and lungs discussed, with series presented.
- Bronchiectasis with over 300 operative cases presented.
- Empyema and its management in the acute and chronic phases.
- Pulmonary abscess.
- Cancer of the lung; surgical removal, with series of cases.

MAURICE G. BUCKLES, M. D., Columbus; thoracic surgeon, Franklin County Tuberculosis Hospital; assistant clinical professor of thoracic surgery, Ohio State University College of Medicine.

RECESS FOR DINNER (No organized dinner.)

6:45 - 7:15 P. M. "Drug Therapy—Streptomycin and Its Uses in Tuberculosis."

- Place of streptomycin in the therapy of tuberculosis.
- Indications and limitations in the treatment of acute and chronic types of pulmonary tuberculosis.
- Use of streptomycin for extra-pulmonary tuberculosis.
- Dosage regimes and routes of administration.
- Toxic complications of streptomycin.
- Development of resistance to streptomycin by the tubercle bacillus.
- Slide demonstration of treated cases.

SIDNEY E. WOLPAW, M. D., Cleveland; assistant clinical professor of medicine, Western Reserve University School of Medicine; assistant department head, Tuberculosis Division, Cleveland City Hospital.

7:15 - 7:45 P. M. **"Community Tuberculosis Control Measures."**

- Four principles in control program.
- Tuberculin tests.
- Mass X-ray surveys.
- General methods in tuberculosis control.
- BCG.

ARNOLD B. KURLANDER, M. D., Columbus; chief, Division of Tuberculosis, Ohio Department of Health.

7:45 - 8:30 P. M. **Panel Discussion:** Dr. Skavlem, moderator, and program participants. Questions and answers from the floor. Physicians attending are invited to bring films which they would like to have discussed by the panel.

LIMA

Wednesday, October 27 American Legion Hall
North and West Streets

"PRACTICAL CARDIOLOGY"

Edwin P. Jordan, M. D., Cleveland, Chairman

A. Carlton Ernstene, M. D., Cleveland, Director of Seminar

(Time Schedule—Eastern Standard Time)

2:00 - 2:45 P. M. **"Coronary Heart Disease."**

- Discussion of diagnosis and treatment of:
- Angina pectoris.
- Acute myocardial infarction.
- Acute coronary insufficiency.
- Paroxysmal cardiac dyspnea (cardiac asthma).
- Adams-Stokes syndrome.
- Congestive heart failure.

A. CARLTON ERNSTENE, M. D., Cleveland; director, Department of Medicine, Cleveland Clinic; president, Cleveland Cardiovascular Society.

2:45 - 3:15 P. M. **"Hypertensive Cardiac Disease."**

- Causes.
- Special problem involved.
- Usual methods of control.
- Prevention or delay by methods used in reducing and controlling blood pressure.
- Discussion of anti-pressor extracts, dietary measures and various types of sympathectomy effective in this condition.

ROBERT D. TAYLOR, M. D., Cleveland; staff member, Division of Research, Cleveland Clinic.

3:15 - 3:45 P. M. **"Rheumatic Heart Disease and Bacterial Endocarditis."**

Rheumatic Heart Disease:

- Establishing the diagnosis, to avoid unnecessary treatment.
- How to handle the acute phase.
- Discussion of subsequent problems: School, athletic activities, occupation, marriage, the future.
- When to use drugs.
- Prophylaxis: Use of sulfadiazine to prevent respiratory infection and reinfection with rheumatic virus.

Bacterial Endocarditis:

- Never occurs as primary infection; always a complication of rheumatic, luetic or congenital valvulitis.
- Recovery now occurs in almost 85 per cent of cases.

- Prophylaxis when tooth extraction occurs by use of adequate doses of penicillin, important.
- Treatment of disease: Adequate dosage of penicillin after determining the sensitivity of the streptococcus to it; should be continued for one month or until signs of infection have disappeared.
- Embolism and subsequent heart failure unfavorable signs.

HAROLD FEIL, M. D., Cleveland; clinical professor of medicine, Western Reserve University School of Medicine.

RECESS

4:00 - 4:30 P. M. **"Cardiac Anxiety Neurosis."**

- Disabling effects.
- Need for adequate information about patient.
- Do's and Don't's for the physician.
- Treatment: Psychotherapy; continued reassurance.

DR. TAYLOR.

4:30 - 5:00 P. M. **"Cardiac Surgery."**

- Accurate diagnosis essential.
- Important role of surgeon in heart disease.
- Field includes: Congenital heart disease (cyanotic type—Tetralogy of Fallot), patent ductus arteriosus, compression of esophagus and trachea between the aorta and ductus arteriosus, pyopericardium (paracentesis or surgical drainage), resection of the pericardial scar in chronic cardiac compression, paravertebral injection or ganglionectomy in severe angina, sympathectomy in hypertension, and surgical treatment of scalenus anticus syndrome.
- Use of penicillin, anticoagulants, and skillful anesthesia in many of above procedures.

DR. FEIL.

5:00 - 5:30 P. M. **"Treatment of Congestive Heart Failure."**

- Methods employed in management of congestive myocardial failure.
- Emphasis on importance of: Adequate period of rest in bed; strict limitation of the sodium content of the diet; use of digitalis and diuretic drugs.
- Indications for oxygen therapy, venisection, and thoracentesis.

DR. ERNSTENE.

RECESS FOR DINNER (No organized dinner.)

7:00 - 8:30 P. M. **Panel Discussion:** Dr. Jordan, moderator, and program participants. Questions and answers from the floor and from the question box.

MANSFIELD

Wednesday, November 3 Mansfield-Leland Hotel

"PRACTICAL DERMATOLOGY"

Thomas E. Rardin, M. D., Columbus, Chairman

Arthur C. Curtis, M. D., Ann Arbor, Mich., Director of Seminar

(Time Schedule—Eastern Standard Time)

1:30 - 2:15 P. M. **"Common Dermatological Disorders of a Primary Nature."**

- Discussion and demonstration of the etiology, clinical picture, diagnostic approach and therapeutic management of these disorders.

EDWARD P. CAWLEY, M. D., Ann Arbor, Mich.; assistant professor of dermatology and syphilology, University of Michigan Medical School.

2:15 - 2:45 P. M. "Contact Dermatoses."

- Discussion and demonstration of weed, cosmetic, airborne, and industrial dermatoses.

ARTHUR C. CURTIS, M. D., Ann Arbor, Mich.; professor and chairman of department of dermatology and syphilology, University of Michigan Medical School.

2:45 - 3:30 P. M. "Common Bacterial and Viral Infections of the Skin."

- Discussion and demonstration of impetigo, warts, herpes simplex, herpes zoster, tularemia, granuloma pyogenica, infectious eczematoid dermatitis and elephantiasis nostras.

STURE A. M. JOHNSON, M. D., Madison, Wis., professor and head of the department of dermatology and syphilology, University of Wisconsin School of Medicine.

RECESS

4:00 - 4:30 P. M. "Deep Mycoses."

- Discussion and demonstration of the visible and visceral manifestations of the deep mycoses, including their diagnosis and management.

DR. CAWLEY.

4:30 - 5:30 P. M. "Cutaneous and Subcutaneous Manifestations of Systemic Disease."

- A discussion and demonstration of skin manifestations associated with fat metabolism disturbances; diabetic or carbohydrate disturbances; leukemia, lymphoblastomas and other blood dyscrasias; disorders of sebaceous and apocrine glands secondary to estrogenic and androgenic secretions.

DR. CURTIS.

RECESS FOR DINNER (No organized dinner.)

7:00 - 7:30 P. M. "A Review of Advances in Dermatologic Management."

- A discussion of material such as is found in the special article of the same title in the 1946 Year Book of Dermatology and Syphilology, pages 7-60, brought up to date.

DR. JOHNSON.

7:30 - 8:00 P. M. Panel Discussion: Dr. Curtis, moderator, and program participants. Questions and answers.

**Second District Symposium at
Springfield Sept. 29**

The Second Councilor District will sponsor a symposium and business meeting, including election of officers, at the Springfield Country Club, N. Fountain Ave., and Home Rd., Springfield, on Wednesday, September 29, beginning at 1:30 p. m.

PROGRAM

1:30 - 2:15—Registration and Opening Session:
Dr. S. C. Yinger, Springfield, President of Second Councilor District, presiding; address by Dr. H. C. Messenger, Xenia, Councilor of Second District; welcome to guests by Dr. F.

A. Halloran, Springfield, President of the Clark County Medical Society.

2:15 - 3:00—Dr. Edward L. Burns, Pathologist, Mercy Hospital, Toledo, "An Academy of Medicine Plan for the Diagnosis of Uterine Cancer by the Papanicolaou Method of Cytological Study."

3:00 - 3:45—Dr. Emmerich von Haam, Department of Pathology, Ohio State University School of Medicine, "Pathological Diagnosis of the Cervix and Uterus."

3:45 - 4:30—Dr. Albert B. Sabin, Department of Pediatrics, College of Medicine, University of

Cincinnati, "Recent Trends in the Epidemiology of Poliomyelitis."

4:30 - 5:15—Dr. L. H. Mendelson, Springfield, "The Differential Diagnosis of the More Common Causes of Abdominal Pain."

5:15 - 6:00—Election of Officers—Business Meeting.

6:00 - 7:00—Dinner.

7:00 - 7:45—Dr. Morton Hamburger, Department of Internal Medicine, Cincinnati General Hospital, "Suppurative Diseases of the Chest."

7:45 - 8:30—Dr. Cameron Haight, Department of Surgery, University Hospital, Ann Arbor, Mich., "The Surgical Treatment of Mediastinal Tumors."

8:30—Announcement of Election Results—Adjournment of Meeting.

Northwestern Ohio Annual Meeting October 5

The regular annual session of the Northwestern Ohio Medical Society, composed of physicians residing in the Third and Fourth Councilor Districts of the Ohio State Medical Association, will be held Tuesday, October 5, at Findlay. All sessions will be held at Findlay College.

Five subjects will be covered in the program. Titles of the addresses will be announced later. Following is a summary of the program which has been arranged:

Pediatrics—Dr. Charles F. McKhann, Professor of Pediatrics, Western Reserve University, Cleveland.

Cancer Detection—Dr. G. N. Papanicolaou and Dr. Henry Cromwell, Cornell University and New York Hospital, New York City.

Medical Economics—Maj. Gen. Paul R. Hawley, M. D., National Coordinator, Blue Cross and Blue Shield, Chicago.

Surgery—Dr. Charles W. Mayo, Director of Section on Surgery, Mayo Clinic, Rochester, Minnesota, and Professor of Surgery, University of Minnesota.

Medicine—Dr. Jonathan C. Meakins, Professor of Medicine and Dean, McGill University, Montreal, Canada.

Sixth District Postgraduate Assembly October 13

The Sixth Councilor District Postgraduate Assembly will be held at the Mayflower Hotel, Akron, on Wednesday, October 13, beginning at 9 a. m.

The following outstanding physicians will be presented as guest speakers:

Dr. I. S. Ravdin, The John Rhea Barton Professor of Surgery, University of Pennsylvania School of Medicine; Professor of Surgery Graduate School of Medicine, University of Pennsylvania.

Dr. Franklin L. Payne, Goodell Professor of

Obstetrics and Gynecology, University of Pennsylvania School of Medicine.

Dr. Henry L. Bockus, Professor of Gastroenterology, Graduate School of Medicine, University of Pennsylvania.

Dr. Julius H. Comroe, Jr., Professor of Physiology and Pharmacology, Graduate School of Medicine, University of Pennsylvania.

PROGRAM

9:00 - 9:30 Registration.

9:30 - 11:20 Symposium on Liver and Biliary Tract;

"The Differential Diagnosis of Jaundice," Dr. Bockus.

"The Pathologic Physiology and Surgical Management of Biliary Disease," Dr. Ravdin.

11:20 - 12:00 "The Diagnosis and Management of Acute Pancreatitis," Dr. Bockus.

12:00 - 1:30 Luncheon.

1:30 - 2:00 Panel Discussion: "Pancreatic and Biliary Tract Disease," Dr. Bockus, Dr. Comroe, and Dr. Ravdin.

2:00 - 2:45 "Significance of Abnormal Vaginal Bleeding," Dr. Payne.

2:45 - 3:30 "Malignancies of the Large Bowel," Dr. Ravdin.

3:30 - 3:40 Intermission.

3:40 - 4:25 "Management of Uterine Fibroids," Dr. Payne.

4:30 - 5:00 Panel Discussion: Dr. F. L. Payne, Dr. I. S. Ravdin.

5:00 - 5:40 "The Pathogenesis and Management of Pulmonary Edema," Dr. Comroe.

6:30 Banquet.

8:00 - 9:00 "Newer Drugs Acting on the Autonomic Nervous System," Dr. Comroe.

Questions to be presented for Panel Discussion by Members should be in writing in order to prevent confusion.

ADVANCE REGISTRATION

Advanced registration should be made by writing Dr. E. W. Burgner, 1140 Cadillac Blvd., Akron, before October 9. A check for \$6, which includes the banquet, should be made payable to Dr. D. R. Mathie, treasurer.

Parking space at M. O'Neil's new parking lot has been reserved for 500 cars. A charge of 50 cents includes all-day parking.

Southeastern Physicians Invited To Muskingum Program Oct. 7

The Muskingum County Academy of Medicine is presenting a special program at a luncheon meeting to be given at Hotel Rogge, Zanesville, on October 7, which will be interesting especially to general practitioners of that section of Ohio.

The following outstanding physicians are on the program:

Dr. Robert J. Reeves, professor of radiology,

Duke University, head of the Department of Radiology since 1931, and writer of innumerable articles in regard to radiology, will speak on "What the General Practitioner Can Expect From X-ray Therapy."

Dr. W. L. Thomas, associate professor of obstetrics and gynecology, Duke University, writer of many articles on those subjects, will speak on "Early Diagnosis and Treatment of Cervical Uterine Lesions."

Dr. Wayne R. Rundles, associate professor of medicine, Duke University, will speak on "Newer Advances in Hematology as Applied to General Practice."

Wives of physicians are invited.

Anesthesiologists Program in Toledo October 1-2

A joint program of the American Society of Anesthesiologists, Inc., and the Ohio Society of Anesthesiologists will be held in Hotel Commodore-Perry, Toledo, October 1 and 2. Following is the program:

FRIDAY, OCTOBER 1, 9 A. M.

1. "Anesthesia for Children," Earl P. Kniseley, M.D., Columbus.
2. "The Care and Sterilization of Anesthetic Equipment," Donald E. Hale, M.D., Cleveland.
3. "Segmental Spinal Anesthesia," A. L. Schwartz, M.D., Cincinnati.
4. "Postoperative Blocks for Control of Pain," J. J. Jacoby, M.D., Columbus.
5. "Hypospray," Robert A. Hingson, M.D., Baltimore, Md.

FRIDAY, 2 P. M.

1. Business Meeting, American Society of Anesthesiologists, Inc.
2. "Anesthesia for Brain Surgery," A. J. Kuehn, M.D., Toledo.
3. "Private Group Practice of Anesthesiology," A. William Friend, M.D., Akron.
4. "Practical Aspects of the Chemistry of Anesthetic Drugs," John Adriani, M.D., New Orleans, Louisiana.
5. Business Meeting, Election of Officers, Ohio Society of Anesthesiologists.

FRIDAY, 7 P. M.

Dinner, Commodore-Perry Hotel; H. Boyd Stewart, M.D., Tulsa, Okla., President-Elect of the American Society of Anesthesiologists, Inc. "Practice of Anesthesiology."

SATURDAY, OCTOBER 2, 9 A. M.

1. "Intra-Arterial Transfusion," G. R. Hamilton, M.D., Cleveland.
2. "An Anesthesia Mortality Study Group," R. J. Whitacre, M.D., Cleveland.
3. "Intravenous Procaine," Ivan Taylor, M.D., Detroit, Mich.

4. Panel on Cyclopropane, Moderator, B. B. Sankey, M.D., Cleveland.

"Personal Experiences with the Use of Cyclopropane," 10 minutes each by J. K. Potter, M.D., Cleveland; A. A. Brindley, M.D., Toledo; and L. E. Larrick, M.D., Cincinnati.

"Complications following Cyclopropane Anesthesia," A. J. Fisher, M.D., Youngstown.

Eclectic Association Elects Officers and Incorporates

The National Eclectic Medical Association, after being organized for one hundred years, recently incorporated under the laws of Ohio. The incorporators are: Dr. C. G. Smith, Marion, past-president; Dr. R. B. Taylor, Columbus, president-elect; and Dr. W. W. Klement, Cincinnati, third vice-president.

The centennial convention of the organization was held at French Lick, Ind., July 13-15. Next year's convention will be held at Cincinnati in June.

Other officers, besides the incorporators, are: Dr. E. F. Flannery, New Castle, Pa., Dr. Nathaniel Broadman, New York City, first vice-president; Dr. R. O. Norris, Tuckerman, Ark., second vice-president; Dr. George C. Porter, Linton, Ind., treasurer; and Dr. John C. Hubbard, 1501 N. E. 11th St., Oklahoma City, Okla., corresponding secretary and editor of the *Eclectic Quarterly*.

Longevity in United States Sets New Mark in 1946

The average length of life of the people of the United States based on 1946 death rates reached a new high of nearly 67 years, according to the Public Health Service. This represents an increase of almost a full year over the corresponding figure for 1945 and an increase of nearly two years over the level prevailing in the immediate prewar period 1939-1941.

The 1946 life tables have been prepared separately for white and nonwhite males and females, and show that the expectation of life at birth for white females is now 70.3 years, exceeding the biblical "three score and ten" for the first time in the history of the nation. On the average, white men do not live as long, their average length of life being 65.1 years.

Albert E. Sidwell, Jr., Ph.D., director of the A. M. A. Chemical Laboratory, recently was elected to the office of chairman-elect of the Chicago Section of the American Chemical Society, the third largest section of that organization.

Rural Health Activities . . .

Committee Expands Program to Farm Families by Issuing Brucellosis Folder; Meets with Farm Organization Leaders To Discuss Problems

TWO forward steps in the rural health program of the Ohio State Medical Association were taken in July by the Committee on Rural Health. One was the publication of a folder warning farm families about the dangers of brucellosis, and the other was the meeting of members of the committee with farm and rural organization leaders to discuss health problems.

The pamphlet on brucellosis tells members of farm families how they may avoid contracting this disease, but does not attempt to go into the subject of treatment. It is one of a series of such educational brochures planned by the committee headed by Dr. Carl S. Mundy, Toledo.

VETERINARIANS COOPERATING

The folder is being distributed concurrently with a companion publication of the Ohio State Veterinary Medical Association, which discusses the farm livestock angle of the disease. Both folders were officially launched at the Ohio State Fair in Columbus August 28-September 3, where the Ohio State Medical Association featured a booth further dramatizing the dangers of brucellosis. The livestock aspects of the disease were presented through an exhibit sponsored by the Division of Animal Industry of the State Department of Agriculture.

The State Medical Association's exhibit also will be shown at the Jackson Apple Festival, September 22-25, under the co-sponsorship of the Ohio State Medical Association and the Jackson County Medical Society; at the Highland County Fair, Hillsboro, September 21-24, under the co-sponsorship of the Highland County Rural Health Council; and at the Circleville Pumpkin Show, October 20-23, in cooperation with the Woman's Auxiliary to the Pickaway County Medical Society. Plans also are under way to book the exhibit at the 1949 Ohio Rural Health Conference and at one or more of the district conferences of the Ohio Rural Health Council.

FOLDERS AVAILABLE

Both folders are being distributed through county agricultural agents and home demonstration leaders and are available on request to farm organizations, 4-H Clubs, veterinarians, vocational agricultural teachers, future farmers and county health officials for further distribution. The

pamphlet is prepared in non-technical terms for the general reader and the message is further driven home with appropriate illustrations. Physicians who wish to obtain copies of either or both folders for distribution to their patients may get them through the Headquarters Office of the O. S. M. A. in Columbus.

News releases informing the public about the drive against the spread of brucellosis were sent to all Ohio newspapers, farm directors of Ohio radio stations and leading magazines. Two special broadcasts of the campaign were presented from radio station W.O.S.U., Columbus, on August 12, and from W.R.F.D., Worthington,

So great has been the initial demand for the brucellosis pamphlet, "Mr. Farmer, Protect Your Family From the Advancing Menace," that a second 50,000 copies has been ordered from the printers. Requests are especially heavy from agricultural agents, health commissioners, farm organizations, and rural physicians.

on August 16. The Ohio State Medical Association was represented on these broadcasts by Mr. Hart F. Page of the Headquarters Office, secretary to the Committee on Rural Health. The Ohio State Veterinary Medical Association also was represented.

MEET WITH FARM LEADERS

The meeting of members of the Rural Health Committee with farm organization leaders had a twofold purpose: To stimulate a better working understanding between the medical profession and others interested in rural health, and to give members of the committee a down-to-earth picture of rural health problems as lay workers see them.

Following an afternoon meeting of the committee on July 22, the group met at the Hotel Fort Hayes in Columbus for dinner and informal discussion with invited guests from the Ohio State Grange, Ohio Farm Bureau Federation, Agricultural Extension Service, 4-H Clubs, and Ohio Rural Health Council.

After an exchange of formalities, guests and members of the committee discussed frankly and

Rural Health Committee and Farm Organization Leaders Meet



A few of the farm organization leaders and representatives of the Ohio State Medical Association's Committee on Rural Health are shown as they met to discuss health problems. Clockwise around the table are: Dr. Taylor, Mrs. Justi, Dr. Lincke, Mrs. Roberson, Dr. Mundy, George H. Lasher, D. V. M., Dr. Brindley, and Mr. Justi. Fourteen others present were out of range of the camera.

informally current health problems now before their respective organizations.

GUESTS PRESENT

Guests were: Mrs. Litta K. Roberson and J. E. Garretson, Columbus, Ohio Farm Bureau Federation; Mr. and Mrs. Wilbur Justi, Columbus, representing Joseph W. Fichter, Master of the Ohio State Grange; George H. Lasher, D. V. M., Rutland, president of the Ohio Rural Health Council; Guy Dowdy, Columbus, secretary of the Ohio Rural Health Council; Sewall O. Milliken, Columbus, extension specialist in rural health organization; and William H. Palmer, Columbus, State 4-H Club Leader.

Members of the Committee on Rural Health present included: Dr. Mundy, who presided; Dr. Jonathan Forman, Editor of *The Journal*; Dr. E. G. Caskey, Mineral Ridge; Dr. William B. Taylor, Jackson; Dr. James M. Snider, Marysville; Dr. J. Martin Byers, Greenfield; Dr. F. M. Hartsook, Cardington; Dr. H. R. Mayberry, Bryan; and Dr. Edmond K. Yantes, Wilmington. Also in attendance were: Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association; Dr. Carl A. Lincke, Carrollton, President-Elect of the Association; and Messrs. Charles S. Nelson, George H. Saville, Hart F. Page, and Gordon Moore, of the Association's Headquarters Staff.

American College of Chest Physicians Fall Courses

The Council on Postgraduate Medical Education of the American College of Chest Physicians is sponsoring three postgraduate courses in the latest developments in the specialty of Diseases of the Chest. Each of the courses will be of one week's duration and are open to all physicians. Tuition fee is \$50 for each course, and registration is limited to fifty physicians for the courses being presented in Chicago and New York City. Reservations will be accepted in the order received.

San Francisco, California, September 13-17.

Chicago, Illinois, September 20-25. Third Annual Postgraduate Course presenting the recent developments in all aspects of diagnosis and treatment of Diseases of the Chest. Course to be held at the Hotel Stevens, Chicago.

New York City, November 8-12. First Annual Postgraduate Course presenting the newer aspects of Diseases of the Chest. Course to be held at the Hotel New Yorker, New York City.

Applications for the courses to be given in Chicago and New York City should be made through the Executive Offices, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Ill.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

STRATEGY REGARDING THE FALL ELECTION

It occurs to us that perhaps the medical profession can take a lesson from the strategy which some of the labor organizations are planning to employ in connection with the current political campaigns. It is reported that they plan to concentrate on plugging for so-called "liberal" candidates for the Congress and state legislatures, and not pay too much attention to the Dewey-Truman scrap, which appears now to be a walk-away for the former.

Obviously, the medical profession should—and will—take an active interest in the battle for the top spot. At the same time, it would be smart for physicians to line up solidly and actively behind qualified and substantial candidates for Congress and the Ohio General Assembly. Too many times, the presidential race draws all the fireworks and the importance of sending good men to Washington and Columbus is overlooked.

It's time for each Ohio physician to get the low-down on those running for Congress and for the State Legislature. The legislative committee of his County Medical Society should have the data. If it doesn't, it's time for it to get busy. Then, it is important that physicians get out and work for those who will make able and safe law-makers.

This year, as always, it's only good sense to want substantial persons manufacturing the law of the land and operating the purse strings of government. The way to have legislators of that caliber is to elect them.

EENY, MEENY, MINEY, MO

We understand that pages 9843-9848 of the *Congressional Record* of August 3 carried a transcript of a debate between Senator Kem (R), Missouri, and Senator Murray (D), Montana, which raises some interesting sidelights regarding the coming Presidential election.

It seems that Senator Kem made a speech lauding Governor Dewey's outspoken stand against "compulsory socialized medicine." Murray didn't like it, whereupon, he made some statements about Governor Warren, vice-presidential candidate, and Warren's advocacy of compulsory sickness insurance in California. Kem contended Warren's views stop at the state border. Murray disagreed.

This standoff, based on information which may

or may not be new to many, leaves the situation something like this:

Dewey says he wants no part of compulsory health insurance. Warren's record indicates he thinks it's o.k. for California; maybe other states. Truman has been asking Congress to pass his national health program, which includes compulsory health insurance. Barkley hasn't barked on this subject but he probably would go along with "the chief."

Write your own ticket.

P.S. We neglected to mention Wallace and Taylor—intentionally.

FIRE SAFETY PROJECT NEEDS YOUR SUPPORT

An Ohio Fire Safety Committee has been appointed by Governor Herbert to assist the State Fire Marshal and other official agencies in an all-out attack to curb what have become staggering fire losses throughout the state. Local committees are being organized in all counties.

This project should have the support of every county medical society and the medical profession in each county should give its active cooperation to the work of the committee. Community organizations of all types will be asked to assist in this worthy project to reduce deaths and disability as a result of fires and curtail a huge economic loss. It's a civic enterprise which should receive enthusiastic support from all civic and professional groups.

BARBITURATE PROBLEM STILL ACUTE

Cleveland City Council will be asked to pass an ordinance to control the use of barbiturates, according to a news release from the Cleveland Division of Health which points out that barbituric acid and its derivatives were the cause of nine suicidal and six accidental poisonings in Cleveland last year.

Indiscriminate use of the barbiturates has become a serious public health problem. The problem can be alleviated somewhat if druggists will not sell these drugs except upon proper prescription and will not refill prescriptions for them without a physician's approval. Physicians can help immensely if they will prescribe only necessary amounts, discourage refills unless absolutely necessary, and curtail dispensing them. Druggists and physicians should warn persons of the dangers involved in continued use of the barbiturates.

Probably the best solution is through legis-



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...now endemic in the U. S.?



Formerly considered a tropical disease, amebiasis is more recently reported^{1,2} as "extremely common" and even "endemic" in this country.

Because early treatment has such an important bearing on prognosis, investigators stress the importance of prompt recognition through careful stool examination.

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RESEARCH
IN THE SERVICE
OF MEDICINE

1. Chalgren, W. S., and Baker, A. B.: Tropical Diseases: Involvement of Nervous System, *Arch. Path.* 41:66 (Jan.) 1946.
2. Browne, D. C.; McHardy, G., and Spellberg, M. A.: Statistical Evaluation of Amebiasis, *Gastroenterology* 4:154 (Feb.) 1945.
3. Manson-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," *Glasgow M. J.* 27:123 (May) 1946.

lation—not local ordinances, but a state law with uniform provisions of state-wide application. Such a measure was sponsored in the last General Assembly jointly by the Ohio State Medical Association and the Ohio State Pharmaceutical Association. It got lost in the shuffle. It is a carefully drafted bill and would be of real benefit. The people of Ohio can have the protection which that measure will offer if they will convince members of the Legislature that it is necessary legislation. The General Assembly will convene in regular session next January.

WANTED: STATESMEN FOR IMPORTANT JOB

Put this in your pipe and smoke it: During the fiscal year which ended June 30, 1948, the Federal Government extracted \$2,663,377,091.01 from Ohio in taxes and levies of various kinds. This was the largest tax collection ever made in the state by Uncle Sam.

How much of this will Ohio get back? Quite a bit less than it put into the pot, you can bet on that.

Which leads to the question: Wouldn't it be more economical and more sensible from many other angles for the states to take over the running of their own business, and, of course, do a better job of financing their own state activities instead of depending on hand-outs from Uncle Sam for that?

Sure it would. But, what's going to be done about it? States (and local communities) continue to take the attitude, "Let Sam do it." Congressmen say: "I'm going to see that my state gets its cut." Uncle Sam says: "The states aren't doing the job, I've got to." Everyone plays both ends against the middle. The result is the taxpayer gets hooked, the states give up rights, and bureaucracy at Washington gets fat and important. If there are any statesmen in circulation, they might really tackle this problem. It isn't one which can be solved by politicians.

NOW WE'RE SURE BROOKINGS REPORT WAS GOOD

The Committee for the Nation's Health, composed of leftists for the most part, has released an attack to try to discredit the report of the recent Brookings Institution which took a hefty poke at compulsory health insurance. Which leads us to believe that the Brookings report is even better than we thought it was.

The C. N. H. charges the Brookings report is contradicted by the conclusions reached by the National Health Assembly. This is baloney because the National Health Assembly did not endorse compulsory health insurance and arrived

at no conclusions which contradict the Brookings report.

Also, Michael Davis and his group charge that if the sponsors of the Brookings report had had the courage to make the report public in advance of the National Health Assembly it would have been "blasted effectively" at that conference. More baloney! The conclusions of the report were released prior to the assembly and were widely published at that time.

Speaking of the National Health Assembly, plans are underway to continue it on a permanent voluntary basis to provide a vehicle for carrying out the recommendations made at the sessions held last May.

Whether or not these plans will materialize will depend, no doubt, on two things: (1) Outcome of the November election which may decide whether or not Mr. Oscar R. Ewing will continue as Federal Security Administrator; (2) outcome of certain Congressional investigations being made of the Federal Security Agency which was sponsor of the National Health Assembly. It seems as if some folks have the opinion that some agency employees are too friendly to known Communists and to Communistic doctrines.

ADVICE ON WORKMEN'S COMPENSATION BLANKS

The Ohio Industrial Commission has reported that an increasing number of physicians who assist at operations or give the anesthetic have been writing the Commission complaining that they have not received blanks for the filing of fee bills.

This is because the attending physician or surgeon has failed to list the name of the assistant on the blank reporting the case. This should be done so the Commission can send fee bill blanks to the assistant.

Also, physicians should remember that the number of a claim should be used in correspondence concerning the claim or in filing a fee bill. The employer is notified of the claim number in each case in which he is involved. The physician can obtain the claim number from him.

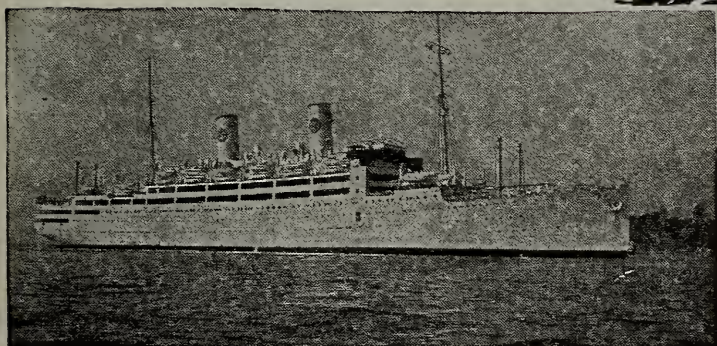
The Commission will send a "reasonable supply" of claim blanks to any physician who writes in for them, the Claims Section has announced.

PROFESSIONAL ANTIVIVISECTION PROMOTERS EXPOSED

If you happen to have handy the July 24 issue of *The Saturday Evening Post*, read or read again, the article, "They're Trifling With Your Life," which exposes the professional promoters behind the antivivisection campaign.

It's a corking good job of uncovering the seriousness of the work which is going on to

**We no longer
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Nor to commonly faulty diets. Today, even the best diet can be bettered in vitamin intake with multivitamin supplementation. Nowadays, the vitamins fundamental to development, organic function and fitness can be administered—*economically* in definite quantities—for therapeutic and prophylactic purposes. Upjohn prepares prescription vitamins in a full range of potencies and formulas to meet the needs of medical and surgical practice.



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obstruct medical progress and the kind of people who are mixed up in the movement.

The article should be brought to the attention of all patients of each physician so they will know what they stand to lose if the promoters and faddists engineering this crusade achieve their objectives.

SOME EXCELLENT P. G. COURSES FOR ALL O.S.M.A. MEMBERS

This issue of *The Journal* might logically be called a "Postgraduate Number." It is hoped that readers will review carefully the instructional programs which will be offered this Fall for the benefit of all members of the Ohio State Medical Association. Plans should be made now to attend as many of the assemblies as possible. All are open to all members. All present subjects of current importance. The speakers are physicians of authority in their fields. Their lectures will be of practical value. What more can the average member desire? Those who fail to take advantage of these opportunities provided for Ohio doctors by the State Association, district societies, and special organizations will be overlooking some real bets.

PREPAID PLANS KEEP ROLLING ALONG

Like Old Man River, the voluntary prepayment medical care plan program keeps rolling along, to the discomfort, probably, of Progressive Party members and the like. For example:

Blue Shield enrollment has now passed the 8,500,000 mark. Michigan Medical Service has 1,075,000 subscribers—the first medical society sponsored plan to exceed the 1,000,000 mark. There are only two states which do not have a prepayment program either in operation or in the stages of organization. Ohio Medical Indemnity, the Ohio State Medical Association plan, is nosing the 400,000 subscriber mark.

IF IT WORKS IN TEXAS IT CAN IN OHIO

Seventy-one private practitioners in Dallas, Texas, are giving health lectures in the public high schools of that city under a program of stated periods worked out jointly with the school authorities.

The plan was started by a few physicians who felt that health instruction should be given by physicians. It worked. Additional physicians joined the volunteer teaching staff. The program appears to be a real success.

If it can be done in Texas, it can be done in Ohio. Why don't you see what can be worked out along this line in your town?

"THE MORE WE OWN, THE LESS I'VE GOT"

Intriguing, indeed, is the story told about the woman of the British Isles who, when questioned about England's nationalization program, offered the following observations:

"This nationalization is a queer thing. We own the Bank of England now, but I am no better off. We own the coal mines, and I have less coal than I used to have. We own the railways, yet I cannot get a seat in a train. This socialism! The more we own, the less I've got."

Now that Britishers have a nationalized health plan, 1948 model, she probably could add: "We own medical services and the doctors, but I get second-rate care because my doctor just can't give much time to anyone of us since he has to see everybody on his panel as often as possible to keep from starving to death, God bless him."

An investment without dividends, we call it!

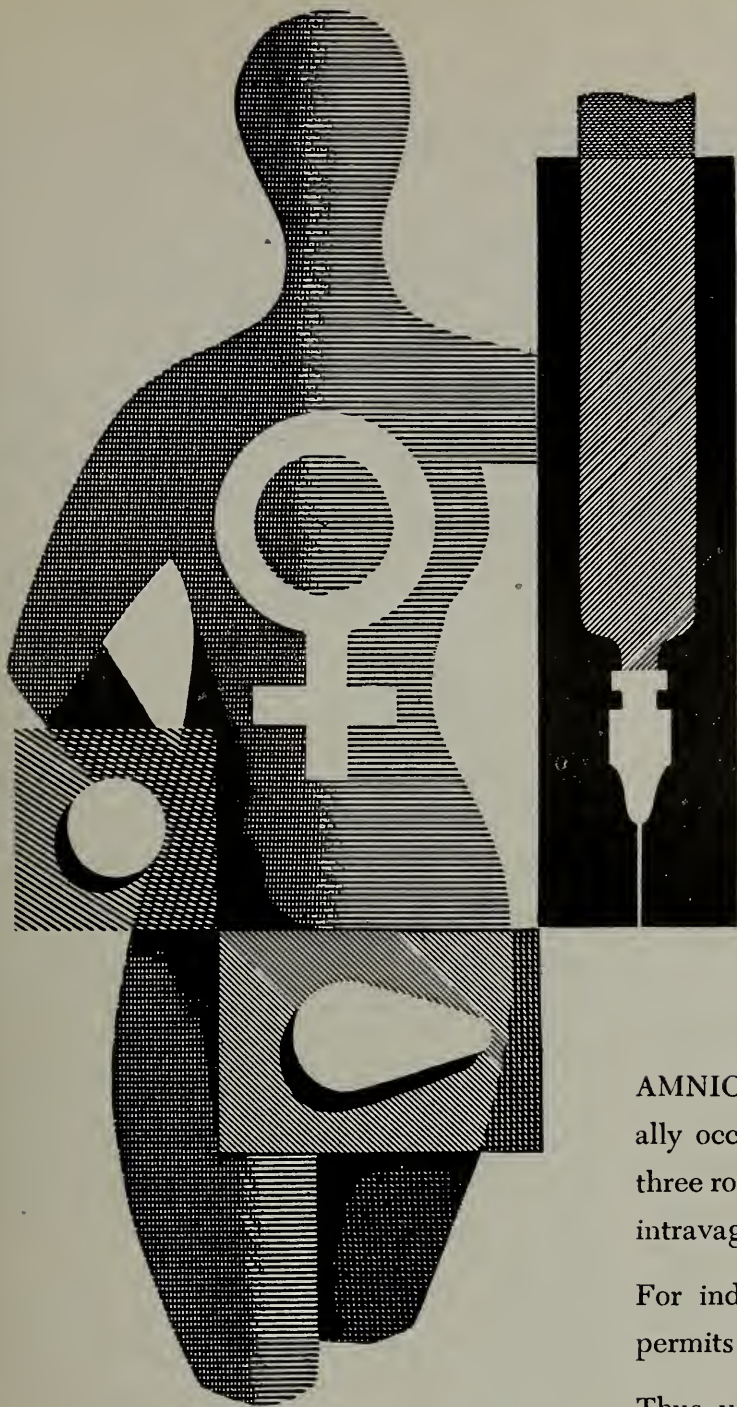
PROPHET WITHOUT HONOR UNLESS A BANDIT

An announcement that a couple of top-flight movie stars expect to pay a Hollywood physician \$20,000 for delivering their baby got quite a play in the newspapers recently and provoked the usual smart-alec editorials in some sheets about doctor's charges, ethics, and the like. Imagine weeping over anything that happens in Hollywood!

About the same time we came across a brief paragraph on the back page of a certain small Ohio newspaper announcing that some new rates had been agreed upon by the doctors of the county—a really rural community. Here they are: Office call, \$2.00; house call, \$3.00; long-distance house call, \$3.00 plus 50 cents per mile one way; normal o. b., \$50.00; premarital examination and certificate, \$10.00; X-ray, fractures, dislocations, per Industrial Commission schedule. Imagine in 1948 A. D.!

That announcement didn't get much publicity. Obviously, it wasn't dignified by an editorial. Too bad!

Nobody gives a hang how often the editorial writers and columnists tee off on the physician who gouges patients, although he's probably beyond saving. But, it would be comforting to see more nice words written about some of the mighty nice things so many physicians do all the time for their patients and the community, so the folks will realize that in the end only a few members of the medical profession can trace their ancestry back to Jesse James.



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SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Licenses Granted . . .

237 Doctors of Medicine Issued Certificates To Practice in Ohio Following State Medical Board Meeting in Columbus August 10

LICENSES to practice medicine and surgery in Ohio were approved for 237 graduates of schools of medicine by the State Medical Board of Ohio at its meeting on August 10, Dr. H. M. Platter, secretary, announced. Those on the approved list took the board examination in Columbus June 21-24.

Highest grade in the examinations was scored by Dr. James W. Haynes, a graduate of Ohio State University, with an average of 90.4 per cent. Two applicants tied for second place with average of 89.7 per cent. They were Dr. Henry L. Hook, Ohio State University, and Dr. Delbert L. Fischer, Western Reserve University. Fourth highest was Dr. Robert W. Merley, Western Reserve University, with 89.1 per cent.

Five graduates of osteopathic schools were successful in passing the required examinations in that field and will receive certificates to practice osteopathic medicine and surgery. Twelve applicants who appeared for additional examinations will receive certificates to practice osteopathic medicine and surgery. In addition, in the limited branches, certificates will be awarded to three mechanotherapists, 11 chiropractors, 25 chiropodists, 20 masseurs and nine cosmetic therapists.

The following doctors of medicine were granted licenses:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE:—John R. Ashcraft, Springfield; Bessie Marks Baker, Columbus; John Wallace Barch, E. Cleveland; Robert Leroy Barth, New Washington; Charles H. F. Beach, Columbus; William T. Binkley, Sidney; Charles G. Bolon, Columbus; Jack R. Bontley, Columbus; Lucian Loring Brock, Jr., Washington C. H.; George T. Brooks, Columbus; Virginia H. Brown, Columbus; John H. Burger, Columbus; Earl R. Burson, Carey.

Timothy Nick Caris, Akron; Daniel G. Cook, Lakewood; Harry R. Custer, Columbus; Robert G. Distelhorst, Columbus; Herbert C. Duber, Cleveland; George W. Duffey, Akron; Robert W. Dustin, Tecumseh, Mich.; Donald R. Dye, Martins Ferry; DeWitt Erk, Columbus; Alvin Essig, Cleveland Heights; Charles B. Foelsch, Jr., New York City; Elliott Foxman, Cleveland.

Abby Franklin, Bellaire; Aris William Franklin, Akron; William J. Gallen, Columbus; Robert E. Gardner, Cleveland; Gordon E. Gifford, Zanesville; Ned T. Gould, Canton; Robert H. Gregg, Los Angeles, Calif.; William L. Hall, Cincinnati; Jay M. Hallauer, Wauseon; Alvis R. Hambrick, Wellston; Chester A. Hanson, Jr., Columbus; Henry L. Hook, Newark.

James W. Haynes, Newark; Allen A. Houda, Eau Claire, Wisc.; Lewis Karl Ingram, Dayton; Stanley Jacob, Youngstown; Paul E. Lacy, Columbus; Robert H. Lanfersrick, Sidney; Elliott

C. Leonhardt, Van Wert; Roland E. Long, Akron; Malcolm MacIvor, Marysville; Mary Margaret Martin, Columbus; Norman L. Marxen, Fostoria; Raymond C. Mellinger, Youngstown.

Paul A. Mori, Jr., Amherst; Marshall C. Morgan, Akron; James B. Overmier, Liberty Center; Ernest J. Penka, Youngstown; Darwin K. Phelps, Powell; Robert K. Rawers, Bergholz; Wilson D. Rees, Columbus; Jerome M. Rini, Shaker Heights; George S. Rogers, Bellaire; Maryjo Roth, Worthington; William B. Schwartz, Upper Arlington.

John H. Sharp, Columbus; Fred H. Slager, Columbus; Lowell D. Smith, Falls Church, Va.; Marvin H. Sobel, Cleveland Heights; Robert B. Stevenson, Columbus; Thomas D. Stevenson, Jr., Columbus; Robert J. Taylor, Toledo; Sidney A. Tyroler, Columbus; Stanley H. Willer, Columbus; Thomas E. Wilson, Niles; Jack Stewart Woodruff, Columbus.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE:—Ira A. Abrahamson, Jr., Cincinnati; Julius Amer, Flushing, Queens, N. Y.; Robert A. Bader, Cincinnati; David D. Barton, Cincinnati; Robert K. Barton, Fountain City, Ind.; Jack H. Baur, Cincinnati; Stanley M. Beck, Jr., Portsmouth; Ernest L. Becker, Cincinnati; Ray Tully Bradford, Cincinnati; Harry M. Brener, Jr., Cincinnati; Edward L. Buescher, Cincinnati; James L. Carvelas, Youngstown; Victor R. Case, Mariemont.

David V. Christiansen, Cincinnati; Fredric R. D'Amato, Campbell; Raymond A. Debo, Wilmington; Victor Dick, Cincinnati; Omer J. Feldhaus, Cincinnati; Kenneth J. Frakes, Quaker City; Ben I. Friedman, Cincinnati; Richard J. Glins, Hamilton; Clinton R. Good, Shaker Heights; Unoji Goto, Cincinnati; James L. Gray, Jr., Cincinnati; Jerome T. Grismer, Dayton; Seymour Jay Harris, Toledo.

W. Morse Hicks, Jr., Cincinnati; Robert L. Hoffman, Cincinnati; Harold H. Hopper, Cincinnati; Thomas Huth, Cincinnati; Murray S. Jaffe, Cincinnati; Winston C. Jesseman, Cincinnati; Carl M. Johnston, Findlay; Nell Kuhn, Cincinnati; Bernard M. Kuhr, Dayton; Francis X. Laubner, E. St. Louis, Ill.; John T. Martin, Cincinnati.

William J. Matre, Reading; Robert A. Matuska, Cincinnati; Roland E. McClain, Lodi; Robert McLelland, Detroit, Mich.; Joseph J. Miller, Cincinnati; Arthur R. Moler, Cincinnati; Hilmer W. Neumann, Cincinnati; Donald B. Nicholson, Cincinnati; Louis J. Nutini, Ft. Mitchell, Ky.; John F. Otto, Jr., Cincinnati; Raymond L. Pfister, Cincinnati; Clifford R. Pollock, Holland; William R. Rundles, Cincinnati.

Robert R. Secrest, Middletown; Roger T. Sherman, Covington, Ky.; Jane Shohl, Philadelphia, Pa.; Thomas J. Siegel, Cincinnati; Julian Silverblatt, Cincinnati; David L. Simon, Cincinnati; Edward S. Strasser, Jr., Cincinnati; Max F. Sudhoff, Toledo; Benjamin F. Suffron, Dayton; Frank N. Suma, Cincinnati.

Albert E. Tennenbaum, Cincinnati; James M.

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**Reprints on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25; No. 11, 590-592.

Vergon, Cincinnati; John J. Vrbanac, Mansfield; David A. White, St. Petersburg, Fla.; Nathaniel R. Whitney, Jr., Glendale; Robert E. Williams, Cincinnati; John C. Willke, Cincinnati; Marian Thornburgh Witt, Norwood; Richard Lee Witt, Norwood; Donald C. Zavala, Owensboro, Ky.; Elmer A. Schlueter, Cincinnati.

WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE:—Thomas S. Arnold, Cleveland; Thurston K. Batson, Columbus; Richard H. Belch; Gibsonburg; Samuel L. Belknap, Demariscotta, Maine; William F. Blank, Akron; Robert E. Boehme, Copley; Howard J. Brown, Ravenna; Merlir B. Budd, Maumee; James C. Bunning, Cleveland; Joe Burge, Jr., Cleveland; William R. Bush, Cleveland.

Carl E. Cassidy, Youngstown; Robert M. Clark, Canton; Howard Kenneth Clough, Cleveland; Robert F. Cooke, Cleveland; James K. Cope, Salt Lake City, Utah; George T. Critz, Cincinnati; John H. Davis, Jr., Cleveland; Anton J. DeFede, Toledo; William R. Dutchman, Forest City Pa.; Arthur B. Eisenbrey, Jr., Shaker Heights; Theodore J. Ferguson, Jr., Oakmont, Pa.; Vergil H. Ferm, Wooster.

Delbert L. Fischer, Dayton; Robert C. Foreman, Cleveland; Donald A. Haas, Findlay; Joseph C. Hadden, Oakdale, Pa.; Mary Beth Hagamen, Saegertown, Pa.; Richard L. Hartzell, Dayton; George R. Hatcher, Jr., Valhalla, N. Y.; William H. Havener, Cleveland; William A. Heflin, Cleveland; Edward C. Held, Akron; William R. Houston, Mansfield.

Phoebe Hudson, Wilmington; Harry F. Hurd, Hiram; S. John Ingram, Cleveland Heights; James C. Jones, Cleveland; Sidney Katz, Shaker Heights; Robert G. Knight, Beloit, Wisc.; Albert C. Lammert, Cleveland Heights; David E. Leavenworth, Cleveland Heights; Harold J. Louis, Cincinnati; Donald R. Lyon, Cleveland; Glenn R. Margard, Cleveland; Perry W. Matlock, Cleveland; Joseph S. McKelvey, Bellaire.

Jack P. Mercer, Tiffin; Robert W. Merley, Cleveland; Robert W. Minick, Gibsonburg; George D. Mogil, San Diego, Calif.; Charles A. Moore, Cleveland; James W. Noonan, Cleveland; Clare M. Parsons, Cleveland; Donald G. Pocock, Cleveland; Jarvis H. Post, Greensburg, Pa.; Albert M. Potts, Cleveland Heights;

L. James Regan, Lakewood; Elizabeth Rice Sawyer, Cleveland; Frank J. Schirack, Canton; Michael M. Scialla, Bridgeport, Conn.; Leon Sholiton, Akron; Dwight S. Spreng, Jr., Cleveland; William V. Trowbridge, Ada; John R. Wagoner, Lafayette, Ind.; David W. Wardell, Lyndhurst; Edward A. Webb, Cleveland.

GRADUATES OF OTHER SCHOOLS: Chicago Medical School—Sol Scholnik, Canton.—Sol Scholnik, Canton.

Dalhousie University, Halifax, N. S.—Walter S. Sellars, Lakewood.

Duke University, Durham, N. C.—Rudolph P. McCulloch, Springfield.

Harvard Medical College, Boston, Mass.—James F. Patterson, Xenia.

Hahnemann Medical College, Philadelphia, Pa.—Carrington G. Arnold, Jr., Cleveland.

University of Illinois, Chicago—William S. Foulz, Cleveland.

Jefferson Medical College, Philadelphia, Pa.—Robert F. Finley, Jr., Dayton; Larrey B. Gale, Newport; and Richard R. Goldcamp, Youngstown. State University of Iowa, Iowa City—Donald K. Harrison, Maumee.

Loyola University, Chicago—Robert J. Baker, Hopedale; Julius D. Menta, Cleveland; and John R. Schlereth, Tiffin.

Meharry Medical College, Nashville, Tenn.—Laland L. Atkins, Cleveland.

New York Medical College—Robert F. Goldberg, Columbus; and Lawrence T. Hadbavny, Cleveland.

Northwestern University, Chicago—Joseph N. Oppenheim, Coldwater.

Syracuse University, Syracuse, N. Y.—Wolfram G. Locher, E. Cleveland.

Temple University, Philadelphia, Pa.—Frederic C. Schnebly, Mt. Vernon.

University of Chicago—Robert I. Barickman, Jr., Columbus; Erwin J. Landon, Cleveland; and Robert L. Sutton, Tipp City.

University of Michigan, Ann Arbor—Evelyn M. Rockwell, Milford.

University of Pennsylvania, Philadelphia—Lee H. Miller, Dayton.

University of Rochester, Rochester, N. Y.—Edward M. Hard, Worthington; and Charles D. Walther, Bradford, Pa.

University of Utah, Salt Lake City—Joseph V. Stevenson, Sayre, Pa.

University of Wisconsin, Madison—George R. Kennedy, Akron.

COMING MEETINGS

Ohio State Medical Association Postgraduate Course, "New Advances in the Treatment of Chest Diseases," Chillicothe, October 21.

Ohio State Medical Association Postgraduate Course, "Practical Cardiology," Lima, October 27.

Ohio State Medical Association Postgraduate Course, "Practical Dermatology," Mansfield, November 3.

Ohio State Medical Association Annual Meeting, Columbus, April 19-22, 1949.

American Medical Association Interim Session, St. Louis, Nov. 30-Dec. 3.

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9, 1949.

American College of Physicians, Annual Session, New York City, March 28-April 1, 1949.

American Congress of Physical Medicine, Washington, D. C., Sept. 7-11.

American Public Health Association, Boston, Mass., Nov. 8-12.

American Society and Ohio Society of Anesthesiologists, joint program, Toledo, October 1-2.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 8.

Northwestern Ohio Medical Society Annual Session, Findlay, October 5.

Second Councilor District Post-Graduate Day, Springfield, Sept. 29.

Sixth Councilor District Post-Graduate Day, Mayflower Hotel, Akron, Oct. 13.

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In Memoriam . . .

Courtland Linden Booth, M. D., Portland, Ore.; Western Reserve University School of Medicine, 1908; aged 71; died July 13. Dr. Booth spent the early part of his life in Erie County, Ohio.

Charles Howard Cale, M. D., Neffs; Starling Medical College, Columbus, 1904; aged 72; died July 23; member of the Ohio State Medical Association and the American Medical Association; president of the Belmont County Medical Society in 1934. Dr. Cale moved to Neffs in 1906. In addition to his medical practice, he engaged in civic affairs of the community, was a member of several Masonic orders, the Elks Club and an honorary member of the American Legion. Surviving are his widow, three sons, and a daughter.

Webb Parks Chamberlain, Sr., M. D., Cleveland; Western Reserve University School of Medicine, 1903; aged 72; died July 20; member of the Ohio State Medical Association and a fellow of the American Medical Association; diplomate of the American Board of Ophthalmology; member of the American Academy of Ophthalmology and Oto-Laryngology. During his 43 years of medical practice, Dr. Chamberlain assumed leadership in religious, educational and civic movements. He was president of the board of managers of the Cleveland Christian Home, a trustee of the Ohio Christian Missionary Society and Chairman of the board of elders of the Franklin Circle Church of Christ. Surviving are his widow, a son, Dr. Webb P. Chamberlain, Jr., also of Cleveland, a daughter, and a sister.

Herbert A. Citron, M. D., Cleveland; University of Cincinnati College of Medicine, 1948; aged 23; died July 7 in Boston, Mass. Surviving are his widow, his parents, and three sisters.

Marcellus Ellsworth Coy, M. D., Dayton; Wayne University College of Medicine, Detroit, 1901; aged 73; died Aug. 1; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Coy continued his medical practice in Dayton until the onset of his illness about a year ago. He was a member of the Lutheran Church. Surviving are three sisters, and a brother.

Ludwig Frank Derfus, M. D., Salem; University of Michigan Medical School, 1911; aged 62; died Aug. 4; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Derfus practiced his profession in and around Salem for 40 years with the exception of time spent in the Army Medical Corps during World War I. Surviving are his widow, and three sisters.

Herman Russell Dewey, M. D., Bellevue; University of Michigan Medical School, 1897; aged 80; died July 30; member of the Ohio State Medical Association and a Fellow of the American Medical Association; vice-president of the Sandusky County Medical Society in 1923. Dr. Dewey began practice in Bellevue 50 years ago. During World War I he served with the Army Medical Corps. He was a member of the First Congregational Church, the Masonic Lodge and the Elks Club. Surviving are a daughter, a sister, and a brother, Dr. F. N. Dewey of Elkhart, Ind.

Ray Samuel Friedley, M. D., Akron; Ohio State University College of Medicine, 1911; aged 60; died Aug. 1; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Summit County Medical Society in 1943; diplomate of the American Board of Pediatrics; member of American Academy of Pediatrics. From 1912, Dr. Friedley was engaged in private practice in Akron until he joined the medical department of the Goodyear Tire & Rubber Co. in 1942. He was past-president of the local Exchange Club and a member of the University Club. Surviving are a daughter, his father, a brother, and two sisters.

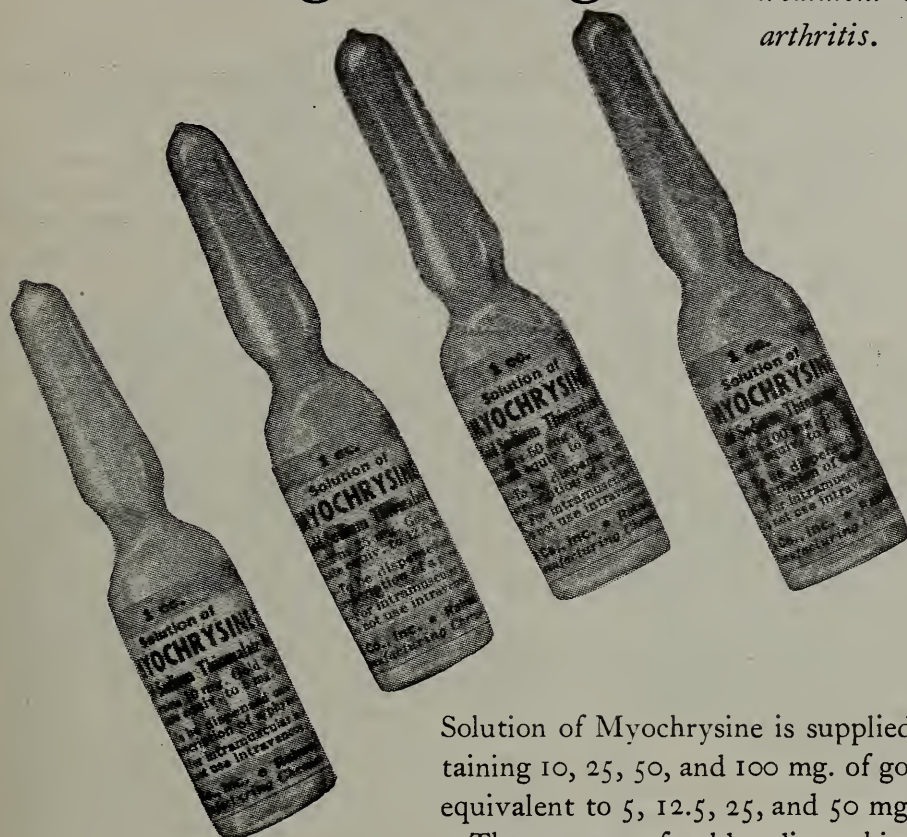
Albert H. Haworth, M. D., Troy; Starling Medical College, Columbus, 1896; aged 78; died July 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Haworth practiced medicine in New Madison, West Milton, and Potsdam before going to Troy in 1920. He served as Miami County health commissioner from 1920 to 1925. Activities other than his profession included membership in the Congregational-Christian Church, the Masonic Lodge and a number of other organizations. Surviving are his widow, and two sons.

Horace Heistand, M. D., Springfield; Medical College of Ohio, Cincinnati, 1891; aged 82; died July 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Heistand was a life resident of Clark County and practiced medicine there for 56 years. Other interests included world travel and the breeding of cattle and horses, as well as an active interest in the business and civic life of the community. He was a member of the Presbyterian Church, several Masonic orders, and the Junior Order of United American Mechanics. Surviving are his widow, and two sisters.

William Joseph Kennedy, M. D., Newark; Georgetown University School of Medicine, 1905; aged 69; died July 16; member of the Ohio State Medical Association and the American Medical

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Association. Dr. Kennedy practiced his profession in Newark for 40 years. For a number of years he was a member of the board of directors of the Newark Trust Company. Surviving are his widow, a daughter, and two sons.

Otto Landman, M.D., Toledo; University of Michigan Medical School, 1887; aged 86; died July 11; former member of the Ohio State Medical Association and the American Medical Association through 1940. Dr. Landman practiced medicine in Toledo from 1890 until his retirement in 1930. He was a member of Collingwood Temple, B'nai B'rith and the Elks Lodge. Surviving are a daughter, and a brother.

Earl Fray Peinert, M.D., Columbus; Ohio State University College of Medicine, 1916; aged 57; died July 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Peinert began his practice in Columbus 29 years ago. During World War I, he served in the Army Medical Corps. He was a member of Phi Rho Sigma fraternity, and several Masonic orders. Surviving are his widow, a daughter, and two brothers.

Harry Edward Schilling, M.D., Cincinnati; Miami Medical College, Cincinnati, 1909; aged 74; died July 4; former member of the Ohio State Medical Association and the American Medical Association through 1931. Dr. Schilling practiced his profession in Cincinnati for 40 years. He was a member of Alpha Kappa Kappa fraternity. Surviving are a son, Dr. Irving O. Schilling, also of Cincinnati, two sisters, and two brothers.

Henry James Schwensen, M.D., Canton; Ohio State University College of Medicine, 1925; aged 54; died July 25; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Schwensen practiced medicine in Canton for 23 years. He was a member of the Methodist Church, several Masonic orders, and the Elks Club. His principal hobby was aviation. Surviving are his widow, a daughter, a son, two brothers, and a sister.

Frank Leslie Snyder, M.D., Fort Lauderdale, Fla.; Ohio State University College of Medicine, 1935; aged 37; died July 29 as the result of a traffic accident. Dr. Snyder was a native Ohioan. Surviving are his widow, two small children, his parents, and a sister.

Eric R. Twachtman, M.D., Cincinnati; University of Cincinnati College of Medicine, 1910; aged 63; died July 11 while on a trip to Maine; member of the Ohio State Medical Association and the American Medical Association. For 35 years Dr. Twachtman was medical director of the Union Central Life Insurance Co., and carried on a private practice. Aside from his professional career, he made an extensive hobby of

collecting stamps, medallions and antiques. Surviving are his widow, two sons, a daughter, and a brother.

Rilie Edward Williams, M.D., Canal Winchester; Starling Medical College, Columbus, 1898; aged 76; died July 9 at Cuyahoga Falls where he moved eight months ago. Dr. Williams practiced medicine for 50 years, 30 years of which were in Canal Winchester. He was a member of several Masonic orders. Surviving are his widow, a step-daughter, and two sisters.

National G. P. Academy To Meet In Cincinnati, March 7, 8, and 9

March 7, 8, and 9 are the dates selected by the Board of Directors for the first Annual Scientific Assembly of the American Academy of General Practice, to be held in Cincinnati next year.

Dr. E. C. Texter, Detroit, who will assume the presidency of the Academy at the close of this meeting, has been appointed by President Paul A. Davis to serve as co-chairman of the Scientific Program Committee. An outstanding scientific program featured by teachers of recognized ability and designed expressly for general practitioners will be presented.

The Netherland Plaza has been selected as the headquarters hotel. The Cincinnati Convention Bureau has allocated rooms in all of Cincinnati's leading hotels for the accommodation of Academy members.

Local arrangements will be supervised by Dr. Joseph Lindner, Cincinnati, chairman of the committee. Mrs. Paul A. Davis, Akron, has been appointed Chairman of the Women's Entertainment Committee.

The state chapters of the Academy in Ohio, Indiana, and Kentucky will act as joint hosts for the meeting.

The annual Assembly will open on Monday morning, March 7, at 10:00 a. m., with a brief business meeting. Scientific papers and symposium will be presented on Monday, Tuesday and Wednesday. The meeting will close on Wednesday, March 9, at noon. The annual banquet will be held on Tuesday evening.

All requests for hotel accommodations should be addressed to Mr. J. S. Turner, Cincinnati Convention Bureau, Dixie Terminal Building, Cincinnati 2.

Joseph Louis Schwind, Ph.D., known to many Ohio physicians as head of the Department of Anatomy, University of Cincinnati College of Medicine, died on May 21, at the age of 45.

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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: *Mil. Surgeon*, 97: 380, 1945. • Shipley, E. R. and Dodd, M. C.: *Surg., Gynec. & Obst.*, 87: 366, 1947 • Mays, J. L.: *J. Med. Assoc. Georgia*, 36: 263, 1947. • Curtis, L.: *Surg. Clin. N. America*, 1466 (Dec.) 1947.

Do You Know? . . .

Dr. Russell L. Haden, Cleveland, has been nominated by the Council on Medical Education and Hospitals of the American Medical Association, to be a member of the National Board of Medical Examiners.

* * *

On the program to judge 4-H Club health exhibits at the Ohio State Fair, August 28-Sept. 3 at Columbus, was Dr. James M. Byers, Greenfield, a member of the Committee on Rural Health of the Ohio State Medical Association.

* * *

Dr. Paul I. Hoxworth, Cincinnati, spoke on "Blood Bank Organization," at the first annual meeting of the American Association of Blood Banks, held in Buffalo, August 26-28.

* * *

Dr. Joseph C. Placak, for 40 years head of the Tuberculosis Division at Cleveland City Hospital, is President-Elect of the American College of Chest Physicians.

* * *

Mac F. Cahal, Chicago, has resigned as executive secretary of the American College of Radiology to become executive secretary of the American Academy of General Practice, with headquarters in Kansas City, Mo.

* * *

The Medical Society of the State of New York has established an education fund for the 58 children of its 32 members who died in World War II. The estimated cost of \$244,000 will be financed by a \$12 assessment to be collected from each member this year through the county medical societies.

* * *

Dr. Harvey F. Garrison, Jackson, Miss., was the winner of the 1948 Cadillac club coupe presented by White Laboratories, Inc., at the American Medical Association annual meeting in Chicago last June.

* * *

Dr. Robert M. Stecher, Cleveland, past-president of the American Rheumatism Association, is a member of the board of directors of a new foundation to promote the study of arthritis and other rheumatic conditions. Dr. W. Paul Holbrook, Tucson, Ariz., is the president.

* * *

According to the National Office of Vital Statistics, the greatest improvement in death rates in the United States among age groups has occurred in children one to four years of age. The death rate in this group dropped from 4.7 in 1933 to 1.8 in 1946, a decrease of 62 per cent.

Each of the 1500 presidents of the local units of the Ohio Congress of Parents and Teachers has received a copy of "Health Appraisal of School Children," a report of the joint committee on Health Problems of the American Medical Association and the National Education Association. This booklet was included in the P.T.A. health packet, with the compliments of the Committee on School Health of the Ohio State Medical Association. The Committee also will have an exhibit at the P.T.A. convention in Cleveland, Sept. 20-22.

* * *

Officers of the Western Reserve Medical Alumni Association for the year 1948-1949 include: Dr. Harold Feil, Cleveland, president; Dr. David A. Chambers, Cleveland, vice-president; Dr. Paul G. Moore, Cleveland, secretary-treasurer; Dr. Charles E. Kinney, Cleveland, trustee, term expiring 1952; and Dr. Leo D. Covert, Bellaire, non-resident trustee, term expiring 1949.

* * *

At the recent session of its legislature, Mississippi became the last state to put a workmen's compensation law on its statute books.

* * *

The National Foundation for Infantile Paralysis has awarded a five-year grant of about \$100,000 to Western Reserve University School of Medicine, to set up a model poliomyelitis training center for doctors, nurses, and physical therapists, under the direction of Dr. John A. Toomey, professor of clinical pediatrics and contagious disease at the university. The first of three ten-day courses for physicians was scheduled to open July 5.

* * *

Dr. Archer C. Sudan, Denver, first winner of the American Medical Association's general practitioner award, has been appointed head of the new division of general practice in the department of general medicine of the University of Colorado Medical Center, Denver. He will also be assistant professor of general practice.

* * *

A comprehensive list of postgraduate courses for physicians available from July 1, 1948, to January 15, 1949, has been compiled by the Council on Medical Education and Hospitals of the American Medical Association. The list was published in the June 19 issue of the *J.A.M.A.*, pages 719-749.

* * *

Dr. Louis H. Bauer, Hempstead, N. Y., a member of the Board of Trustees of the American Medical Association, has been selected as secretary-general of the World Health Organization, with headquarters in New York City.

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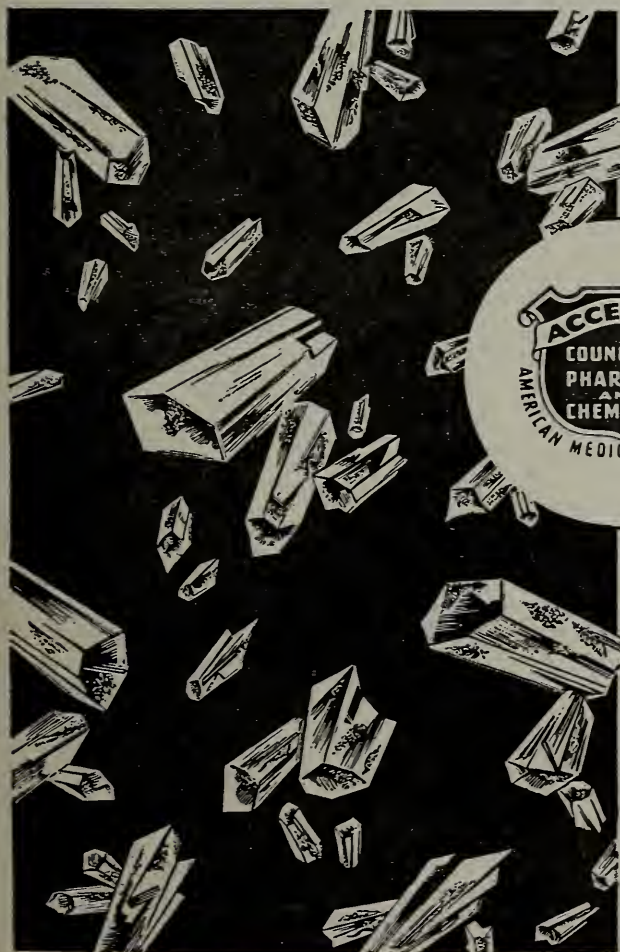
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Koch Hoax Gyps Taxpayers . . .

U. S. Senator Langer Uses Public Funds to Propagandize "Cure" Of Detroiters Whose Claims Remain Unsubstantiated After Probes

JUDGING from the number of inquiries received from members of the Columbus Office, a good many Ohio physicians had the dubious honor of receiving one of the leaflets entitled, "The Koch Treatment," a reprint of certain remarks inserted in the *Congressional Record* for June 7 by Senator William Langer, North Dakota.

Anyone familiar with the history of Koch and his experiments with alleged cures for cancer would, of course, not get too much excited about this broadside, except possibly to be amazed that taxpayers' money can be used for the distribution of such trash. However, it is likely that the propaganda went to uninformed and gullible persons. For that reason, it would be well for physicians to prime themselves to answer intelligently questions which may be shot at them by patients.

EXPOSED BY A.M.A.

The following article published in the August 7, 1948, issue of *The Journal of the A.M.A.*, is sufficient to show that Langer, knowingly or innocently, lent his name and office and has wasted public money to foster Koch's unsubstantiated claims:

* * *

In the *Congressional Record* for June 7, 1948, by unanimous consent, appeared an article which had appeared in a so-called Lutheran magazine known as *The Eleventh Hour*. The article bears the title "The Koch Treatment" and begins as follows:

Fortunately for Canadian farmers in the Province of British Columbia, the Minister of the Department of Agriculture possessed an open mind . . .

Such ailments as Bang's disease, Johne's disease, and other fatal diseases that customarily make devastating demands upon dairy herds, are no longer fatal in British Columbia. Thanks to the integrity and foresight of Canadian physicians, veterinarians, and Government experts who recently completed a series of successful experiments with the Koch system for treating virulent diseases.

A reprint of the extension of remarks of the Honorable William Langer of North Dakota appeared in a leaflet which bore a notation across the top: "(Not printed at Government expense)." The manila envelope in which this leaflet was distributed in the United States mails to an unknown number of Doctors of Medicine bears a notation that it was manufactured in the U. S. Government Printing Office, and the envelope and its contents were sent through the United States mails without the payment of postage. This is not the first time that the taxpayers of the United States have been called

on to undergo an expense on behalf of Dr. William F. Koch of Detroit. A criminal prosecution in the Federal court at Detroit involved two trials, neither of which, unfortunately, ended decisively. The first trial occurred in 1943, beginning on January 12 of that year and ending on May 28 with a hung jury. A second trial, with the same set of facts, charging the same violation of law, started Feb. 19, 1946. It ended because of the illness of a juror, on July 24 of that year.

LOOK AT THE RECORD

The "open-mindedness" of the Department of Agriculture of the Canadian province mentioned is part of the record of the 1946 trial. Such open mindedness consisted, apparently, of accepting a so-called scientific experiment conducted by a salesman for the Koch Laboratories in Canada, a veterinarian in the employ of that laboratory, and a veterinarian in the employ of the Province of British Columbia, who happened, also, to be secretary of the Veterinary Association of that province.

The testimony brought forth that "glyoxylide," one of the names Koch uses for his alleged cancer "cure," was administered to a number of selected cows, which showed excellent results in the reduction of fibrosis, even to the extent of the complete disappearance of fibrosis in some of the cows afflicted with mastitis. The report was then submitted to a committee who admittedly had never seen any of the cows, and that committee, acting on the information received from the three persons mentioned, issued a report on the effectiveness of the treatment.

The testimony of the three "scientists"—the salesman in the employ of the Koch Laboratories and the claimed disinterested veterinarians—was followed by a member of the committee. He was a professor in veterinary science at the University of British Columbia. He admitted on cross examination that the laboratory findings in mastitis, the only disease condition in which a pretense of laboratory check was made, did not show improvement of the cows beyond the material course of the disease. He testified that the laboratory findings were discarded and clinical findings only were considered. He further admitted, with respect to complete disappearance of fibrosis, that he and other members of the committee had accepted the report of the three "investigators." He also, but rather reluctantly, admitted that if he had been misinformed of the results obtained, his conclusions and opinions expressed would also be wrong.

WHAT COMMISSION FOUND

Would it be too embarrassing to Senator Langer, who has lent his name to this piece of pseudoscientific nonsense, if he could now incorporate in the *Congressional Record* a recital of the facts brought out in a clinical experiment conducted at Ottawa, Canada, under the observation of Dr. R. E. Valin of Ottawa and other qualified medical observers appointed by the Canadian Cancer Commission? Testimony in

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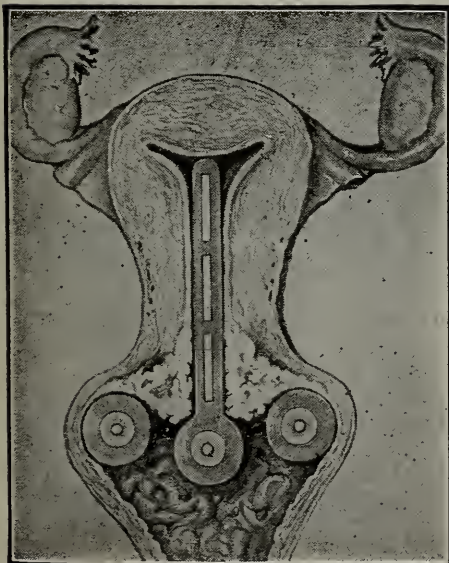
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the trial indicated that the Canadian Cancer Commission filed a report that they had been unsuccessful in their efforts to obtain samples of Koch's glyoxylyde for laboratory work but that they did receive some of the material for clinical use. Nine patients with positive results in biopsies for cancer were treated with the drug by Dr. Arnott, Koch's Canadian representative. All 9 patients were dead within a period normally expected for such cases, and in no instance was there any improvement or relief from pain. The report of the commission, which is dated Feb. 7, 1943, concluded with this statement: "A careful review of all of the evidence presented at this date fails utterly, in the opinion of the commission, to support the claim made on behalf of the Koch treatment that it is either a remedy or a cure for cancer."

American College of Surgeons

The thirty-fourth Clinical Congress of the American College of Surgeons will be held in Los Angeles, with headquarters at the Biltmore Hotel, from October 18 to 22, 1948. The program of scientific sessions on subjects in the fields of general surgery; eye, ear, nose, and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic, and neurological surgery, will be supplemented by operative clinics in hospitals in Los Angeles and vicinity by showings of operations by television and motion pictures, and by a four-day hospital standardization conference for hospital personnel, according to Dr. Irvin Abell of Louisville, Chairman of the Board of Regents of the College. There will also be extensive technical and scientific exhibits.

Michigan State Society Postgraduate Conference

Doctors of medicine from Ohio are invited to attend the 1948 Annual Session and Postgraduate Conference of the Michigan State Medical Society which will be held in Detroit at the Book-Cadillac Hotel, September 22-24, according to P. L. Ledwidge, M. D., Detroit, President of the Society.

The program of scientific sessions in the fields of medicine and surgery will feature many of the outstanding physicians and surgeons in the United States. Among the 31 guest essayists are: F. H. Lahey, M. D., Boston, Mass., Waltman Walters, M. D., Rochester, Minn., R. W. TeLinde, M. D., Baltimore, Md., Haven Emerson, M. D., New York N. Y., L. H. Dragstedt, M. D., Chicago, Ill., Alexander Brunschwig, M. D., New York, N. Y., and S. P. Reimann, M. D., Philadelphia, Pa.

More than three thousand physicians are expected to visit the Session which will feature, in addition to the scientific sessions, an extensive exhibit presented by leading manufacturers of surgical instruments, X-ray apparatus, operating room and hospital equipment, pharmaceuticals and others.

To insure hotel accommodations for the Session write E. C. Texter, M. D., Chairman of Housing Committee, 1005 Stroh Bldg., Detroit, Michigan.

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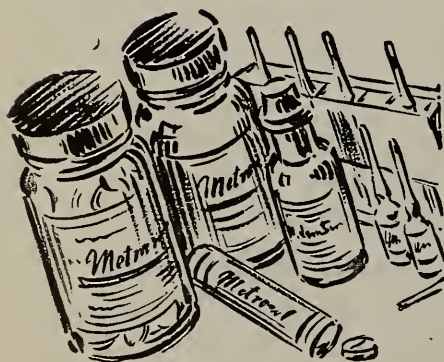
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Are You Registered To Vote? . . .

About 30 Districts in Ohio Require Voters To Register In Person;
For Those Not Already on the List, the Deadline Is October 4

EACH Ohio physician should exercise his franchise to vote in the November 2 General Election. Therefore, he is advised to check his status and make sure he will be qualified. The placing of qualified voters' names on the registration list is automatic in many sections of the State, but there are about 30 registration districts in which voters are required to appear before the respective boards of election and register in person. The deadline to register is 28 days before the election, or October 4.

Following are a few pertinent facts about registration with excerpts from the Ohio Election laws:

"Every citizen of the United States who is of the age of 21 or over, who possesses the qualifications herein. (Ohio Election Laws) required, shall be entitled to vote at all elections." Sec. 4785-29.

"No person shall be permitted to vote at any election unless he shall have been a resident of the state one year, of the county forty days and of the voting precinct forty

days next preceding the election at which he offers to vote . . ." Sec. 4785-30.

Prospective voters who moved recently are taken care of in this provision:

"... that any qualified elector who in good faith moves his residence from one precinct to another precinct in the same county at any time subsequent to the fortieth day preceding an election shall have the right to vote at such election in the precinct from which he moved . . ." Sec. 4785-30.

"PERMANENT" REGISTRATION

A citizen who voted at any election within the last two years and has not moved his residence is still legally registered and need not do so again, according to the following:

"At the close of each calendar year after the year of the general registration the election authorities shall examine the registration lists for the purpose of eliminating excess names; and to the end, whenever it appears that a registered voter has not voted at a



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general, special or primary election at least once in two calendar years, or transferred his registration within that period, his registration card or form shall be taken from the original and duplicate files . . ." Sec. 4785-53.

(The above provision applies only to those living within registration districts.)

" . . . When once registered in accordance with this act, an elector shall not be required to register again unless his registration is cancelled for reasons as hereinafter provided." Sec. 4785-35.

The place to register is the headquarters of the Board of Elections of the county or municipality in which the citizen lives. In general, the boards maintain regular business hours for registration and other business.

WHERE REGISTRATION IS REQUIRED

"In every city which at the last preceding Federal census had or which at any local, state, or Federal census provided by law, shall have reached a population of 16,000, or more, the board of elections shall establish and maintain, in the manner herein provided, a registration of all the qualified electors of such city.

"Any municipality of less than 16,000 population may, by ordinance, elect to become a registration municipality. . . . The board of elections, in a county containing a registration city when it is deemed necessary to prevent fraud in elections, may require registration of voters in suburban municipalities, or territory contiguous or adjacent to such registration city. . . ." Sec. 4785-34.

STUDENTS

"If any person shall attend any institution of learning which is located in a county other than the county in which the voting resident of such person was located immediately preceding the time he commences to attend such institution, and if such person while so attending such institution, shall reside in the county in which such institution is located, his voting residence, while so attending such institution, shall be deemed to be at that location in the precinct in which it was located immediately preceding the time he commenced attending such institution." Sec. 4785-33a.

REGISTRATION IN PERSON

The privilege of absentee voting does not extend to registration. A citizen must register in person; the only exception being in cases of disabled persons who may apply for special privileges. Sec. 4785-57.

Any person previously absent from the state because of military service who has not registered since returning should ascertain whether or not his registration is still good. The registration of a person absent in military service is subject to the same regulations as those of other citizens.

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Buckeye News Notes . . .

Alliance—Dr. R. L. Rutledge, immediate Past-President of the Ohio State Medical Association, addressed a recent meeting of the Alliance Rotary Club on the subject, "How'll You Have Your Doctor?"

Columbiana—Dr. Harry Bookwalter resigned after more than 20 years on the Columbiana County Board of Health. His successor is Dr. Chester W. DeWalt.

Columbus—Dr. Berger Thomas, who has just concluded two and one-half years of postgraduate work in neurosurgery at the Lahey Clinic, Boston, has accepted a one-year teaching assignment as assistant professor of neurosurgery, University of Edinburgh, Scotland.

Lorain—Dr. I. C. Riggin, formerly of Suffolk, Va., resumed his duties as the city's new commissioner of public health. He was Lorain County health commissioner in 1925-27.

Mansfield—At a recent meeting of the Kiwanis Club, Dr. John L. Stevens related his experiences on a recent trip with Mrs. Stevens to the Hawaiian Islands.

Oberlin—Dr. Robert H. Browning, director of the Sunny Acres Tuberculosis Sanitarium in Cleveland, has accepted the position as director of the Oberlin College health service.

Prospect—Dr. Alston E. Morrison of Marion recently addressed a public gathering sponsored by the Civic Health Club on the subject of cancer.

Ravenna—Dr. Edgar H. Knowlton, Mantua, was elected for his 20th term as president of the Portage County Health Department.

Toledo—Dr. Edward J. McCormick, member of the Board of Trustees, was one of five A.M.A. officials who flew to Japan to inspect the medical care program at the invitation of General Douglas MacArthur.

Dangerous Products Circulated

Two warnings issued recently by the Federal Food and Drug Administration will be of interest to physicians.

One warning was concerning the sale in Ohio and other states, probably through grocery stores, of bottles, labeled castor oil but containing turpentine. One such brand is the "Nasco Brand," sold by the National Specialty Co., Nashville, Tenn. The other is marketed by the Pennex Products Co., Pittsburgh.

Druggists and physicians were urged by the Administration to return all stocks of siliform ampuls to the manufacturer, The Heilkraft Medical Company, Boston, Mass., as this injection drug, which should be sterile, is potentially dangerous since samples were collected on the market containing living organisms.

for September, 1948



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, *Amer. J. Clin. Pathology*, 74:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, *J. Amer. Med. Tech.*, 8:606-14 (Sept.) 1947.

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F. B. I. Wants This Man

Ohio physicians have been asked by the Federal Bureau of Investigation to be on the lookout for one Hugo Bob Hubsch who may turn up in this state, and if so probably will contact



HUGO BOB HUBSCH

the medical profession for one reason or another. He has been known also by the aliases Robert C. Glass, R. C. Harris, Hugo Hobsch and Louis S. Miller.

On November 7, 1945, a Federal Grand Jury at Jackson, Mississippi, returned an indictment charging this man with a violation of the National Stolen Property Act. He is charged with another violation of the National Stolen Property Act in a complaint filed with a U. S. Commissioner at Birmingham, Alabama, on June 7, 1948. This individual has defrauded numerous physicians and hospitals.

According to the F. B. I., investigation has revealed that Hubsch, in an effort to obtain narcotics and sedatives, frequently contacts physicians and hospitals in the following manner: He claims that he is suffering from a chronic kidney ailment and pretends that he is then in considerable pain. He frequently asks for an X-ray picture and in making himself ready for the picture places a small stone under the right side of his back in the exact position of the right kidney. The X-ray taken in this manner makes it appear that he has a large kidney stone in the right ureter near the kidney. The X-ray photograph tends to confirm the representations of the fugitive and he often obtains sedatives, narcotic prescriptions or treatment from the physician or hospital contacted. In return for such services, he gives fraudulent checks.

The following is a composite description of Hugo Bob Hubsch: Age, about 52, claims to have been born Budapest, Hungary, November 4, 1895; height, about 5' 6"; weight, 140 to 170 lbs.; hair, dark brown, graying; eyes, brown; build, medium; race, white; nationality, believed to be naturalized American; occupations, laborer, pharmacist; scars and marks, left arm partially paralyzed, needle scars on both arms, large scars above each hip resulting from kidney operations, shrapnel scars and two bullet scars on abdomen, bridge in upper front teeth; characteristics, long nose, stooped posture.

Anyone having information concerning the whereabouts of this fugitive should immediately notify the nearest office of the Federal Bureau of Investigation or your local law enforcement agency.

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FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting October 25.

GYNECOLOGY—Intensive Course, two weeks, starting October 11. Vaginal Approach to Pelvic Surgery, one week, starting October 25.

OBSTETRICS—Intensive Course, two weeks, starting October 25.

UROLOGY—Intensive Course, two weeks, starting September 27.

MEDICINE—Intensive Course, two weeks, starting Oct. 11. Personal Course in Gastroscopy, two weeks, starting Sept. 27, Nov. 8. Gastro-Enterology, two weeks, starting Oct. 25. Hematology, one week, Oct. 4.

DERMATOLOGY—Formal Course, two weeks, starting Oct. 4. Clinical Course every two weeks.

OPHTHALMOLOGY—Intensive Course, two weeks, starting September 20. Refraction Methods, four weeks, starting Oct. 11. Ocular Fundus Diseases, one week, starting November 15.

OTOLARYNGOLOGY—Intensive Course, two weeks, starting October 18.

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Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

THE NATIONAL CONVENTION

The registration for the twenty-fifth annual meeting of the Woman's Auxiliary to the American Medical Association which met in Chicago in June was 841. Our State report was proudly read by our State President, Mrs. E. Benjamin Gillette. Twenty-seven delegates and alternates from Ohio were registered for the meetings. Mrs. Roswell Fidler, Columbus, was elected to the Nominating Committee for 1949. Mrs. Luther H. Kice is the new National President.

A detailed report of the convention will be given in the next issue of *Medical Auxiliary News*.

DISTRICT MEETINGS

Plans for District meetings are already being made. Mrs. Fred Brosius, Middletown, Director of the First District, had a luncheon and committee meeting at the Terrace Plaza Hotel, Cincinnati, recently to make plans for their district meeting which will be held at the Cincinnati Club, October 11.

BUTLER

The Woman's Auxiliary to the Butler County Medical Society has undertaken a project of significance for the coming year. Each Friday afternoon, members of the auxiliary alternate in bringing flowers and magazines to the Butler County Tuberculosis Sanatorium for the pleasure of patients, and in serving the latter with varied kinds of refreshment. Two doctor's wives serve in this way each week bringing ice cream, cookies and lemonade and other refreshments to the patients. In addition, the auxiliary has purchased a water cooler for the convenience of convalescing patients and has recently purchased lawn furniture for donation to the sanatorium. The committee in charge of the sanatorium project includes Mrs. Charles Hauser, chairman, Mrs. Azel Ames, Mrs. Edward Keating, Mrs. Ralph Leyrer of Hamilton, Mrs. W. H. Henry, Mrs. Ross Hill, and Mrs. E. T. Storer of Middletown.

FRANKLIN

Members of the Executive Board of the Woman's Auxiliary to the Columbus Academy of Medicine entertained with a luncheon on July 27 at the Scioto Country Club honoring Mrs. George T. Harding, III. Mrs. Harding, who had been elected to serve as president of the auxiliary for 1948-1949, left Columbus August 1 with her husband for Los Angeles where Dr. Harding has accepted the presidency of the College of Medical Evangelists. Mrs. Wayne Brehm, who took over the presidency of the auxiliary, announced at the luncheon other new officers and committee chairmen who will serve this year. The officers

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include: Mrs. Hugh J. Means, president-elect; Mrs. Ruskin B. Lawyer, vice-president; Mrs. Miner Seymour, recording-secretary; Mrs. A. L. Kefauver, corresponding-secretary; Mrs. John A. Riebel, treasurer; and Mrs. Donald J. Alspaugh, past-president.

MONTGOMERY

The officers for the newly organized Woman's Auxiliary to the Montgomery County Medical Society are: Mrs. A. D. Cook, president; Mrs. S. E. Flook, president-elect; Mrs. N. C. Hochwalt, vice-president; Mrs. H. J. Staton, recording-secretary; Mrs. Morton E. Block, corresponding-secretary; and Mrs. R. L. Haas, treasurer. The second meeting of the auxiliary was held in the main dining room of the Hotel Van Cleve on June 11. Eighty-one were present at the luncheon. Visitors present were Mrs. George Cooperrider, Columbus, state vice-president; Mrs. E. P. Greenawalt, Springfield, director of the Second District; and Mrs. Fred Brosius, Middletown, director of the First District. Mr. Paul W. Goss, director of the Safety Council of the Dayton Chamber of Commerce, was the guest speaker.

Civilian Physician Wanted at Erie Ordnance Depot

A civilian physician is needed at the Erie Ordnance Depot, Lacarne (Ottawa County), Ohio, to replace the present Army medical officer who is being transferred.

The staff at the post dispensary consists of the medical officer, a nurse, a medical technician and stenographer. All equipment and supplies are furnished. The position pays a salary of \$6,235.20 per year for a forty-hour week, with overtime for emergencies outside of regular hours.

Consideration will be given a physician who plans on retiring in a few years. Living quarters at a nominal cost will be available if the physician desires to reside on the reservation. Further information may be had by writing or visiting Col. J. E. McNerey, commanding officer.

Dr. Kemp Returns To Baylor

Dr. Hardy A. Kemp, dean of Wayne University College of Medicine, Detroit, and previously dean of the Ohio State University College of Medicine, Columbus, has been named professor of preventive medicine and chairman of the department of public health and preventive medicine at Baylor University College of Medicine, Houston, Texas. Dr. Kemp was on the faculty at Baylor from 1928 to 1939, when he became dean of the University of Vermont College of Medicine. During World War II he was a colonel in the army medical corps.

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Practical Scientific Exhibit Planned For Interim A. M. A. Session

The A.M.A. Council on Scientific Assembly met at A.M.A. headquarters Saturday, July 24, to outline plans for the St. Louis Interim Session. The Council on Scientific Assembly and the committee on Scientific Exhibits are working closely together to coordinate the papers, clinical demonstrations and exhibits—all directed to the general practitioner.

Among the topics to be presented are diabetes, heart disease, cancer, poliomyelitis, obstetrics, pediatrics, dermatology, genito-urinary conditions, jaundice, laboratory diagnosis, X-ray diagnosis and physical medicine as applied to the treatment of arthritis. Diagnosis and treatment will be stressed with clinical demonstrations wherever possible.

Papers will be read at the General Scientific Meetings in the St. Louis Opera House from 9 to 10 a. m. and from 2 to 3 p. m. each day. It is planned to have at least six demonstration units going each half day in the Scientific Exhibit from 10:30 a. m. to 12 noon, and from 3:30 p. m. to 5 p. m. Small rooms will be provided for these demonstrations and provision is being made so that physicians can take all the notes they wish in comfort. There will be intermissions in the program from 10 to 10:30 a. m., 12 noon to 2 p. m. and 5 p. m. to 6 p. m. each day so the doctors can visit the scientific and technical exhibits. These exhibits will be open from Tuesday noon to Friday noon, November 30 to December 3.

The American Diabetes Association, American Cancer Society, American Heart Association, and the National Foundation for Infantile Paralysis are among the organizations which will be asked to contribute in one way or another to the scientific program.

Dr. Ernest B. Howard, assistant to Dr. George F. Lull, secretary and general manager of the A.M.A., has been appointed secretary of the Council on Scientific Assembly for the St. Louis meeting.

New Hospital Rates Allowed

Following extended negotiations between the State Relations Committee of the Ohio Hospital Association and the State Industrial Commission, the ceiling per diem rate for Workmen's Compensation cases in Ohio hospitals has been increased to \$12.11 or \$12.36, if X-ray examinations are furnished by the hospital. The new contract will be in effect until June 30, 1949. Comparable rates last year were \$10.25 and \$10.50.

Dr. Philip Earle Blackerby, 67, Kentucky State Health Commissioner for a number of years, died at his home in Louisville on June 24.

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Ohio Golf Tournament . . .

Physicians From All Parts of State Make Gay Event of Contest At Granville Inn Course; Two Doctors Tie for Top Honors

By Robert W. Elwell
Executive Secretary, Toledo Academy of Medicine

THE 23rd Annual Tournament of the Ohio State Medical Golfers' Association was held on July 19 at the Granville Inn Golf Course. The golfing enthusiasts were given full cooperation by the local weather bureau in that sunny skies prevailed all day. Excellent food and the enthusiastic spirit of the members contributed to one of the most successful meetings of the Association.

When the final scores were tabulated it was found that two of the better golfers had deadlocked for the Association Championship. Dr. H. B. Kaufman, Zanesville, and Dr. R. C. Young, Toledo, played the 27-hole event in identical gross scores of 117. Their scores by nines were: Kaufman 42-38-37; Young 39-38-40. Due to conditions it was not possible to play off the tie and Drs. Kaufman and Young were declared Co-Champions for 1948. Dr. Kaufman was defending champion having won the water polo golf contest at Westwood Country Club in Cleveland in 1947.

After flipping a coin, Dr. Kaufman was awarded the President's Prize donated by Dr. Jerome Zeigler—a combination radio and alarm clock. We know Dr. Kaufman will arise each morning under most pleasant conditions. Dr. Young was the winner of a complete Rexair Cleaning Unit donated by the Martin-Parry Corporation. There will be no dust on R. C. now.

18-HOLE EVENT

Dr. F. M. Green, Columbus, was successful in capturing the 18-hole Crown with a score of (40-40)80. Dr. C. M. Larrick, also of Columbus,

was right behind him for the runner-up title with a score of (39-42)81.

Dr. Green's prize was a portable radio presented by Dr. A. A. Brindley, Toledo, President of the O. S. M. A. Dr. Larrick went home with a physician's bag as his prize.

NEW HANDICAP SYSTEM

The Board of Directors of the O. S. M. G. A., in an effort to establish a fair system of handicapping voted to try the Peoria System. It is a method of sampling certain holes (known only to the scorer) from each person's score and computing by tables the player's handicap for the day.

This year's tournament was set up on the basis of three flights, with handicaps determining the flight into which a player is placed. The



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following tabulation of scores is given with net scores shown:

Flight "A" Handicap (0-13)
27-Holes

G. M. Wilcoxon, Alliance	106
Wm. Lovebury, Columbus	107
Chas. Donatelli, Toledo	109
J. H. Rinehart, Springfield	109

18-Holes

Wm. Morrison, Columbus	72
H. D. Emswiler, Columbus	73
R. A. Keating, Columbus	74

Flight "B" Handicap (14-18)
27-Holes

Jim Oims, Toledo	99
R. P. Beli, Cleveland	102
J. Zeigler, Cincinnati	107

18-Holes

J. C. Woodland, Mt. Vernon	69
D. A. Weir, Mansfield	76
H. C. Ashton, Basil	77

Flight "C" Handicap (19-30)
27-Holes

L. W. Cellio, Columbus	107
L. W. High, Millersburg	113
G. A. Foster, Coshocton	114

18-Holes

J. H. Pollock, Newark	72
John Conwell, Cleveland	74
A. A. Brindley, Toledo	75

INTER-COUNTY TITLE

The four-man team of Columbus was out in front of Cleveland competition to win by a total of 326 strokes against Cleveland's 344. The members of the Columbus team and their gross scores were—Lovebury 79, Green 80, Morrison 83, and Emswiler 84. The Ohio State Medical Association is to furnish suitable trophies or medals to the members of the winning team.

1949 TOURNAMENT

The annual business meeting of the Association was called to order by the President, Dr. Jerome Zeigler. Reports were given by the By-Laws Committee and the Nominating Committee. The Treasurer reported an approximate surplus of \$40.00 would exist after all expenses of the tournament were paid. The following officers were elected: Dr. Sam Zuker, Toledo, president; Dr. George Wilcoxon, Alliance, president-elect; Dr. Floyd Green, Columbus, vice-president; and Bob Elwell, Toledo, secretary-treasurer.

Dr. Joseph Rinehart of Springfield extended an invitation to the O.S.M.G.A., to hold the 1949 Tournament in his city. The private club that will handle the tournament has fine facilities and Dr. Rinehart stated a fine group of prizes would be secured by the local committee. This location was unanimously agreed upon for 1949. It was also agreed that the tournament be held early in June on either a Wednesday or Thursday.

All Ohio golfing doctors are urged to join in the fun and good-fellowship of the 1949 Tournament at Springfield.

P. S. A large blue and red golfer's umbrella belonging to some member of the Association was left at the Scorer's table and can be claimed by writing to Bob Elwell, 1420 Monroe Street, Toledo 2, Ohio.

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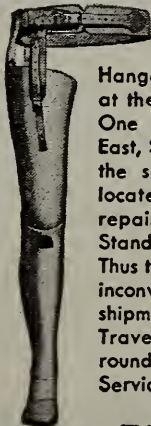


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Ohio Needy Aided By Acts Passed At Special Legislative Session

At the recent special session of the Ohio General Assembly, several measures affecting Ohio's public assistance programs and welfare institutions were passed and signed by Governor Herbert. Following is a review of the laws enacted, published in the *Newsletter* of the Ohio Citizens' Council for Health and Welfare, Columbus:

Assistance grants to Ohio's more than 120,000 needy aged and 3,400 needy blind citizens will be increased an average of approximately \$5 per month next October to bring them more nearly in line with today's greatly inflated basic living costs.

At the same time more funds will be available to provide for the needs of approximately 29,500 of the more than 45,000 Ohio children who are partially or entirely dependent on public agencies for their support or care and protection.

The money for the increased aid will come from Federal funds made available by Congressional action just before Congress quit work prior to the recent national political conventions. Necessary amendments to Ohio's laws to enable our state to "pass on" the additional Federal funds to its needy aged and blind were enacted at the Special Session of the Ohio General Assembly last month. (Such amendments were unnecessary insofar as the Aid to Dependent Children law is concerned.)

Statutory "ceilings" on monthly grants for recipients of Aid for the Aged and Aid for the Blind in Ohio were raised from \$50 to \$55 by the Special Session enactments.

Besides making possible the "passing on" of Federal funds to provide additional assistance for the aged and the blind, the General Assembly appropriated \$4,500,000 of state funds for welfare purposes.

Of this amount, \$3,000,000 was a supplemental appropriation for "poor relief," usually referred to as "general relief," to enable the state to reimburse local governments for 50 per cent of their 1947-48 expenditures for this responsibility. Governor Herbert pointed out that the inclusion of hospital care of the indigent as a part of poor relief, as provided in a 1947 act, was largely responsible for increased expenditures. (Rapidly

rising living costs had something to do with it, also!)

The remaining \$1,500,000 from state funds was for maintenance for Ohio's welfare institutions, \$1,200,000 of it being "earmarked" for food and \$300,000 for fuel. There are approximately 40,000 persons in the state's 27 mental hospitals and institutions and penal and correctional institutions.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since July 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ALLEN COUNTY R. G. Hendershot, Lima	Buford H. Burch, Columbus Eunice E. Bryan, Columbus Arthur M. Call, Columbus Charles J. Deishley, Columbus Jack H. Welch, Columbus
CLARK COUNTY Edwin E. Ash, Springfield John M. Summers, Springfield	
CLINTON COUNTY Malcolm M. MacRae, Blanchester	GALLIA COUNTY Jacob Weinberger, Gallipolis
COSHOCTON COUNTY Fountain C. Beattie, Coshocton	HAMILTON COUNTY Max Krakauer, Cincinnati S. Gregory Miceli, Lockland
CUYAHOGA COUNTY A. B. Friedman, Cleveland Allen J. Reisenfeld, Cleveland Edward C. Svec, Cleveland	RICHLAND COUNTY Pearl O. Staker, Mans- field Kenneth G. Werts, Lexington
FRANKLIN COUNTY Richard H. Brooks, Columbus	WAYNE COUNTY C. A. Bates, Dalton

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Industrial Health Section on Safety Conference Program

Attention of physicians is called to the Industrial Health section of the 10th annual Ohio State Safety Conference which will be held at the Hotel Statler, Cleveland, Wednesday, Sept. 22, beginning at 9:45 a. m. The entire conference covers a three-day period, Sept. 21-23.

The Council of the Ohio State Medical Association named Dr. R. L. Rutledge, Alliance, immediate Past-President, to represent the Association on the Safety Conference.

PROGRAM

1. "Potential Hazards in Handling Radioactive Materials in Industry," Mr. F. Van Atta, National Safety Council, Chicago, Illinois.
2. "Health Hazards Connected with the Use of Certain Metals," Dr. H. H. Schrenk, Chief of Health Branch, United States Bureau of Mines, Pittsburgh, Pennsylvania.
3. "The Significance of Biological Tests in Evaluating Industrial Health Hazards," Dr. Palmer L. Beebe, Director of Laboratories, Dept. of Industrial Hygiene, School of Medicine, University of Pittsburgh.
4. Open Forum.
5. Election of Sectional Officers.

Chairman of the section will be Herbert G. Dyktor, Commissioner, Division of Air Pollution Control, City of Cleveland. Vice-chairman will be Fred S. Mallette, Industrial Hygienist and Toxicologist, Firestone Tire & Rubber Company, Akron.

Chicago Medical Society

The Chicago Medical Society is sponsoring two postgraduate courses in September to be given on the campus of Northwestern University Medical School, Chicago.

The first course in Hematology and Neurology will be given the week of September 13-18. The second course in Cardiovascular and Respiratory Diseases will be offered the week of September 20-25.

Both courses are limited to 100 and are open to physicians in good standing in their local medical societies. For copy of program and application write Doctor Willard O. Thompson, Chairman, Committee on Postgraduate Medical Education, Chicago Medical Society, 30 North Michigan Avenue, Chicago 2.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

ASSOCIATE general practitioner wanted in Ohio town of 40,000. Must curtail my practice on account of illness. Marvelous opportunity for young physician; fully equipped office; possibility to take over practice. Box 34, Ohio State Medical Journal.

FOR SALE: Picker, Army, Mobile, X-ray Field Unit, 30 MA, new and accessories, tank, cassettes, hangers, viewing box, apron, gloves; Reasonable. Also, Picker, Army, Field Fluoroscopic and Radiographic Unit, 15 MA, new; Reasonable. Location, Cleveland, Ohio. Box 37, Ohio State Medical Journal.

YOUNG DOCTOR wanted to take over good general practice and to share air conditioned office in desirable part of Cleveland, Ohio. Write to R. Denholm c/o 4875 W. 12th St., Cleveland 9, Ohio.

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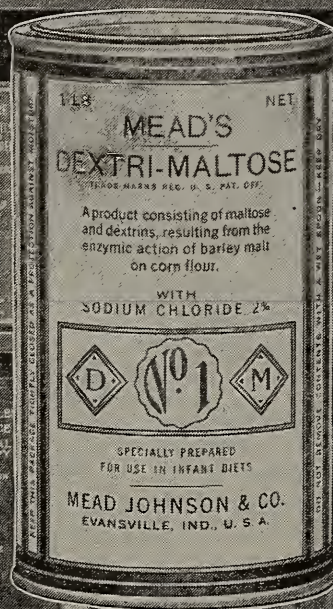
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(1) Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: *Am. J. Dis. Child.* 61:1 (July) 1943.

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The Physician's Bookshelf

By Jonathan Forman, M.D.

Individuals Vary Continuously In A Rhythmic Pattern

Man, Weather, Sun, by William F. Petersen, M.D., (\$10.00. *Charles C. Thomas, Publisher, Springfield, Illinois*) presents a detailed study of the extremely complex integration of the human organism and the inorganic environment in which man exists, i.e., the air mass in which we have our being.

The conclusions that Dr. Petersen draws from this study are, in fact, confirmation of the folk-experience of the human race and its transmission as an interpretation of the oneness of the organic and the inorganic world.

Dr. Petersen first integrates the day-by-day reaction of a set of adult human triplets with the weather and the time. He then shows that the population as a whole reveals a comparable pattern of reaction in terms of psychoses, the births, and the deaths. Finally, the reactions of the population are limited to the solar rhythms that apparently govern the organic world now as they did in the beginning.

The lesson that you and I can learn from this extensive piece of original investigation is that we physicians must not only consider the patient as a whole but we must also always consider him in relation to the totality of his heredity and environment. Petersen also shows that in the total environmental situation the change in the air mass in which the organism exists is probably of major significance in the sum total of the effectors; that the effector mechanism primarily involves a tide of oxygen inadequacy followed by a phase of correction and overcorrection. Anoxia provides the stimulus which may be followed by different organic reaction patterns but genetically identical individuals react alike.

To me, the author has contributed the most when he showed that neither Man nor his environment are ever static. The individual varies continuously in a rhythmic pattern in which all biochemical and biophysical processes participate. I once had the pleasure of introducing Dr. Petersen to the medical students at Ohio State University and to watch the faces when he showed how the blood count and the basal metabolic rate as well as blood chemistry varied in rhythmic fashion from hour to hour. To these students, single analytical determinations had great value. Petersen, however, showed them to their amazement and dumbfoundment that the patient is not to be regarded solely from the anatomical and static but rather from the func-

tional and dynamic side; he must be regarded as a whole in the environment as a whole.

As a student of medical history, your reviewer would say after learning of Petersen's work, especially with this set of triplets (medical students), that we physicians had better retrace our steps and pick up the thread of disease-cause which we had when the Bacteriologist with his germs interrupted us in the study of the ecology of Men.

Vascular Diseases in Clinical Practice, by Irving Sherwood Wright, M.D., (\$7.50. *The Year Book Publishers, Chicago*) presents the excellent teaching of another specialist who complains that the curricula of the modern medical schools neglect his field. The author insists on complete surveys of the vascular system and emphasizes the whole system rather than the local manifestation. He insists that cardiologists should be prepared to interpret cardiovascular disease in the broadest sense and be prepared to care for all diseases affecting the blood vessels as well as the heart. For this important and rather new point of view, the book demands reading by every physician.

The Engaged Couple Have a Right To Know, by Abner I. Weisman, M.D., (\$3.00. *Renbaylor House, Publishers, New York City*) is a modern guide to happy marriage by the author of "You Too Can Have A Baby" and "The Xenophus Lairs in Pregnancy Diagnosis." It is not presented as a panacea, nevertheless, the book does give much of the needed information and gives insight to many of the problems about to be encountered. It is proper that it should be addressed to the couple about to become a biologic unit. The success of modern marriage depends upon an inner cohesion, an inner unity between husband and wife. This comprehensive source-book for the engaged couple will aid materially in the development of this inner unity.

Life, Its Nature and Origin, by Jerome Alexander, (\$5.00. *Reinhold Publishing Corporation, New York City*) describes a specific mechanism to account for the origin and development of biological life. The story of how inanimate particles become living organisms which later develop sensitivity and intelligence is told with a thorough background of scientific evidence and the minimum of theory by this distinguished scientist. Every physician who has given a thought to the philosophy of science will enjoy this book and find it a real challenge to his imagination.

The Ranks of Death—A Medical History of the Conquest of America, by Colonel P. M. Ashburn, (\$5.00. *Coward-McCann, Inc., New York City*) is a delightful book of fourteen fascinating chapters: The diseases of the new world; how the Negro was more resistant to the imported diseases than the Indian and how he was used in his stead for a slave; The Medicine of the Conquest; Famine and Scurvy; The Eruptive Fevers—Malaria, Yellow Jack, The Pale Killers, TBC, et al.; Intestinal Infections and Parastic Worms; The Kiss of Death: Syphilis; Leprosy, Leishmaniasis and Trachoma; Landwehr.

The author proposed one most important question, in the answer of which may lie one of the clues to the future: "Among the results of the conquest of America were the permanently established diseases. To this total the Indian contributed very little; the whiteman, smallpox, measles, possibly typhus, possibly the venereal diseases, and surely, some of the respiratory diseases; the Negro paid his way with a legacy of malaria, yellow fever, hookworm, probably dysentery, possibly syphilis, and numerous other lesser maladies Granted the large effect that disease had on the conquest of America, how did it happen that the white man suffered relatively so little! What was it that made the white race better able to withstand the blows of illness than the Indian or the Negro?"

A History of the Heart and the Circulation, by Frederick A. Willius, M.D., and Thomas J. Dry, (\$8.00. *W. B. Saunders Company, Philadelphia*) is an excellent collection. First there is a chronological presentation of the knowledge relating to the heart and circulation in Antiquity, the Medieval Era, the Renaissance, the 17th Century, the 18th Century, the first half of the 19th Century, the second half of the 19th Century, the first quarter of the 20th Century—a total of 224 pages.

The second part consists of twenty special biographies, carefully chosen, from Hippocrates to Sir Thomas Lewis—137 pages. Finally, the chronological presentation of dates according to subjects—86 pages, six-point type.

Give Your Child A Chance, by Lenore Turner, (\$1.50. *The Georgian Press, Inc., 175 Varick St., New York City*) is a little book that parents can well afford to study—especially those whose first-born has raised the question as to "just when it is that he is supposed to bring us joy?" It gives enough of the right material and not too much.

Principles of Healthful Living For the Individual and For the Community, by E. F. Van Buskirk, Ph.D., (\$3.50. Text Edition. *The Dryden Press, New York City*) is written for first and second year college students. It is thoroughly

up to date and expertly arranged to help the student grasp the essentials. Physicians who find it necessary to prepare talks and radio scripts on matters of hygiene will find it most helpful in arranging their material.

Your Skin and Its Care, by Howard T. Behrman, M.D., and Oscar L. Levin, M.D., (\$2.50. *Emerson Books, Inc., New York City*) is a cleverly written text by the authors of "Your Hair and Its Care." In these days of cosmetics and in the age of hucksters, such information should be in the hands of all of our women.

Coronary Heart Disease, by A. Carlton Ernstene, M.D., (\$2.50. *Charles C. Thomas, Springfield, Illinois*) is one of the monographs of the American Lecture series. This is a book that most physicians will want to read. First, because this disease is responsible for the largest single group of organic disturbances of the heart and secondly because it is the usual cause of death among physicians. Dr. Ernstene, of our own Association, has done an outstanding job in bringing together all that is worth-while in 86 easily read pages.

An Introduction to Medical Psychology, by L. E. Wexberg, M.D., (\$3.50. *Grune & Stratton, New York City*) is the first textbook in this field. It should be well worth while for those of us who did not study this subject in our premedical course to read this clear, brief statement of the subject.

Recent Advances in Surgery, by Harold C. Edwards, (\$6.50. Third Edition. *Blakiston Company, Philadelphia*) is a British work of continued high excellence, designed to bring the surgeon who has gotten behind in his reading, up to date. It is quite up to the standards maintained consistently by this series of "Recent Advances."

Principles Governing Eye Operating Room Procedures, by Emma I. Clevenger, R.N., (\$5.50. *C. V. Mosby Company, St. Louis, Missouri*) does just what the name implies—provides a brief, easily understandable direction for the conduct of "an eye operating room." It is by the Supervisor of the eye operating room at New York Eye and Ear Infirmary.

Physical Education—Interpretations and Objectives, by Jay B. Nash, Ph.D., (\$3.00. *A. S. Barnes & Company, New York City*) emphasizes that a rich recreational life contributes to efficiency and builds up reserves of organic power. With the push on to teach health in the schools, physicians who are interested in our school systems should read this book so as to be able to cooperate with the physical educator instead of spurning him because though he is a trained education, he does not have a M.D. degree or the viewpoint of curative medicine.



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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON,
Managing Editor—Bus. Mgr.

R. GORDON MOORE,
Asst. Managing Editor

Congenital Hypertrophic Pyloric Stenosis

JEROME GIUSEFFI, JR., M. D., and PAUL W. SUTTON, M. D.

FEW disease entities respond more dramatically to operation than does that of congenital hypertrophic pyloric stenosis. Extensive experience in large clinics throughout the country has been recorded in the literature, amply substantiating the above conclusion. The following is reported in further support of this general record.

The present analysis is concerned with the operative experience encountered at the Children's Hospital in the period 1930 through 1947 inclusive. During that interval 200 cases of pyloric stenosis were subjected to pyloromyotomy according to the method of Fredet Rammstedt. The Children's Hospital is a private hospital, and therefore the analysis includes the operative results of numerous operators. This seemingly varied group, however, gathers a uniform character when it is noted that the senior author (P.W.S.) operated upon 121 cases, and that an additional 60 cases were operated upon by house officers under his direct or indirect supervision or by surgeons connected with the Department of Surgery at the University of Cincinnati, College of Medicine. There remain, therefore, only 19 cases whose technical management may deviate in great degree from the general outline presented.

The literature is replete with extensive reviews and descriptions of the prevalent concepts concerning the etiology of this disease, as well as the clinical symptoms and findings which are important in making the diagnosis. No attempt will be made to re-emphasize this particular phase.

GENERAL DISTRIBUTION OF CASES

This series consists of 200 cases, 164 males and 36 females. The striking predilection (86 per

The Authors

● Dr. Giuseffi, Cincinnati, Ohio, is a graduate of University of Cincinnati College of Medicine, 1942; and is assistant resident in surgery, Cincinnati General Hospital.

● Dr. Sutton, Cincinnati, Ohio, is a graduate of Johns Hopkins University School of Medicine, Baltimore, 1921; diplomate, American Board of Surgery; chief of staff, surgical department, Children's Hospital, Cincinnati; and associate professor of clinical surgery, College of Medicine, University of Cincinnati.

cent) for this disease to involve males is borne out by this ratio. Ladd and Gross¹ had a similar experience, four-fifths of their patients being males; Donovan² found the disease to be seven times more frequent in the male than in the female. The following list indicates the manner in which these patients appeared in the hospital and were operated upon:

1930	2 cases	1939	6 cases
1931	4 "	1940	11 "
1932	2 "	1941	21 "
1933	3 "	1942	11 "
1934	6 "	1943	10 "
1935	6 "	1944	13 "
1936	14 "	1945	20 "
1937	11 "	1946	26 "
1938	5 "	1947	29 "

The increasing frequency of the disease seems explicable on the basis of greater awareness of this entity by the pediatricians, more frequent diagnosis, and the universal agreement that surgery is the therapy of choice.

The well-recognized propensity for the dis-

Submitted April 2, 1948.

ease to afflict first-born members of the family has been confirmed in the series, and the manner in which it involves the numerical offspring is listed below:

First	born	90 cases	Sixth	born	2 cases
Second	"	55 cases	Seventh	"	2 cases
Third	"	19 cases	Eighth	"	3 cases
Fourth	"	10 cases	Ninth	"	1 case
Fifth	"	8 cases			

In ten cases the birth order was unknown.

AGE AT ENTRANCE TO HOSPITAL

Ladd and Gross mention that vomiting seldom occurs before the ninth or tenth day after birth, and usually not before the child is two weeks of age. The average age in our patients at the onset of symptoms was three weeks; the average age at the time of hospital admission was five weeks. The greatest number of cases (58) were admitted when they were four weeks of age. This is in direct agreement with the experience of Ladd and Gross and Lanham and Mahoney.³ The latter authors lay great emphasis on the significance of the age of the patient on admission to the hospital. In their experience, patients six weeks of age or over carry a higher operative mortality rate (13.7 per cent) than do those patients who are less than six weeks of age (3 per cent). Our series is too small to comment on this conclusion except to say that empirically it is our opinion that patients six weeks of age or older have had the disease longer than the younger patients, that postoperatively their course is stormier and apt to be punctuated by intermittent spells of vomiting, and that convalescence and gain in weight is slower.

OPERATION

In the last twenty years the mortality rate from pyloromyotomy has been steadily declining. This decline can be attributed to two important factors: the recognition (1) that congenital stenosis does not constitute an operative emergency, and (2) that a great deal can be accomplished by the preoperative administration of parenteral fluid to prepare the patient for operation and increase his operability. Here, an average of four days has been utilized in the preoperative preparation of the patient. This time is well spent in the administration of subcutaneous or intravenous fluids in order to correct the state of alkalosis, chloride deficit, and blood and protein needs wherever indicated. When the patient's blood chemistry and clinical appearance approach normal, the operation is carried out. One hour prior to the operative procedure, the patient is given a gastric lavage because of the dangers associated with aspiration of vomitus during and subsequent to the period of anesthesia. We have not found it necessary to administer preoperative sedation.

The anesthesia of preference, in our opinion, is drop ether. This agent was utilized in 173 cases of this series, whereas 21 cases were performed under local anesthesia. In six instances the anesthetic agent was not listed. These patients tolerate ether anesthesia very well, and its use enables the procedure to be performed with considerably more ease than with local. This is well borne out by the fact that the operating time in this group of patients averaged 26 minutes, whereas the operative time under local anesthesia averaged 45 minutes. The procedure under local is usually prolonged by the active resistance of the patient, which in turn not infrequently exhausts him more thoroughly than general anesthesia. In addition, it is the opinion of qualified observers that local anesthesia sometimes interferes with wound healing, a matter of considerable importance in these debilitated patients.

PROCEDURE

We prefer the high right rectus incision, and this has been used invariably. The incision is made beginning superiorly at the costal margin and extending inferiorly for a distance of approximately two inches. Bleeding points in the abdominal wall must be caught and meticulously controlled. The peritoneal cavity is entered and it will be noted that the liver underlies the greater portion of the incision. It is gently retracted superiorly. Thereafter the pylorus is delivered into the wound where it is steadied between the thumb and forefinger of the operator's left hand, his assistant in the meantime making slight traction on the more proximal portion of the stomach. An incision is then made through the avascular area of the pylorus with a knife, extending through the serosa and into the muscular layer, making certain to traverse the longitudinal limits of the tumor. The remainder of the dissection is done bluntly by means of a small curved mosquito hemostat separating the fibers of the muscularis layer down to the submucosa. It is wise to initiate this blunt dissection at the stomach side of the incision where the danger of perforating the mucosa is not imminent. Once the incision is clearly defined down to the submucosa, the fibers toward the duodenal end can be separated more easily and with greater care so as to divide all the fibers and yet keep from perforating the duodenum. At the end of this dissection the submucosa should pout perceptibly and easily into the wound. There will always be a small amount of bleeding from the wound, but this is usually easily controlled by the application of warm wet packs. When this does not suffice, the individual bleeding points may be controlled by the use of either interrupted Lembert or figure of eight sutures of fine black silk placed through the edge of

the muscle layer on either side of the incision.

It is the distinct preference of the senior author to close the abdominal wound entirely with silk, as has been done in 152 cases. In 16 cases the peritoneum has been closed with catgut, and the remainder of the abdominal wall with silk. In 19 cases catgut has been used throughout. In the remaining 13 cases information concerning the closure of the abdominal wound is not available. Closure of the peritoneum is performed by a continuous suture of fine black silk, begun at the inferior angle of the wound. Here the desirability of the high rectus incision becomes obvious, for the liver acts as a superb tamponade for the underlying viscera preventing these organs from protruding into the wound, and allows quick and secure closure of the peritoneum.

The peritoneum and the posterior rectus sheath are closed as a single layer, and importance is attached to catching a good bite of peritoneum and posterior rectus sheath on either edge of the wound. The anterior rectus sheath is closed with interrupted figure of eight ligatures of fine black silk, and the skin is closed with interrupted Lembert sutures of the same material. Postoperatively the baby is started on water by mouth six hours after operation, at which time he receives 8 cc. In the next 24 hours, first on a two-hour and then on a three-hour schedule, the infant is fed an increasing volume of mixed water and formula, the amount of formula in the mixture being increased in graduated amounts until he is receiving whole breast milk or formula normal for his age. In the ensuing postoperative days the amount of formula is gradually increased varying with the ability of the patient to take increasing amounts and the degree of his appetite. If the child is not receiving intravenous fluids, it is our practice to supply fluids subcutaneously during the day of operation and the first postoperative day. Sutures are customarily removed on the seventh postoperative day.

RESULTS

In the series of 200 cases there have been four deaths, or a total mortality of 2 per cent. This coincides closely with the mortality rate of Ladd and Gross, who report 2.7 per cent in their last 331 cases, and of Donovan who reports a mortality rate of 1.8 per cent in his series of 508 cases. The deaths may be listed briefly as follows:

Case 1. Expired 9 days postoperatively from an intraperitoneal hemorrhage, presumably from the pyloric incision.

Case 2. Developed gastroenteritis after the first week postoperative, and expired 21 days after operation.

Case 3. Had an explanatory laparotomy, during which time the Rammstedt procedure was done for a small pyloric tumor. He also had a resection of a Meckel's diverticulum.

He died the day of operation, and at necropsy was noted to have a stenosis of the rectum.

Case 4. Died the day of operation, clinically of circulatory failure. No necropsy was obtained. It was the clinical impression that the patient had received too much intravenous fluid.

There have been no deaths since 1937 or in the last 152 cases. Two cases in this series required re-operation. One of these cases, however, was referred to us from another hospital after the first Rammstedt procedure had been performed. In both instances these children did poorly after the first operation, continued to vomit and show evidence of high obstruction. At re-operation it was felt in both cases that the first incision had not extended through the duodenal limit of the tumor. After re-operation recovery was satisfactory.

Most authors emphasize very strongly the danger of evisceration in these patients who are generally debilitated and have a low protein reserve. Fortunately there have been no eviscerations in this series. There have been three superficial infections, two occurring in cases in which catgut was used, the third representing small stitch abscesses of a wound closed with silk from which silk sutures were subsequently extruded. In a series including the efforts of numerous operators and in which both catgut and silk closures of the wound have been utilized, it seems difficult to predicate the success obtained against evisceration to any particular surgical maneuver. If there is any single surgical practice which we believe to be noteworthy, it is the effort to make the rectus incision high so that subsequently the liver will underlie the incision and act as a buttress over an otherwise weak area of the abdominal wall. We believe that the fact that there have been no eviscerations commends not so much any special surgical technique as it does the fine pediatric care which these patients receive in this hospital to counteract their debility and supply the necessary nutritional factors requisite for successful wound healing.

INADVERTENT OPENING OF THE DUODENUM

Every author on this subject points out small margin of safety which the operator has in dissection of the tumor at the duodenal end, indicating the great facility with which the duodenum may be inadvertently opened in this location. The duodenum has been opened accidentally in 12 cases, and in another instance the operator was not certain that he had entered into the duodenum but treated it as such. Numerous methods such as that suggested by Lamson⁴ have been proposed to extricate the operator when this mishap has occurred. These methods seem unduly complicated. In all 13 instances our method has been simple closure of the perforation by approximating the serosa and muscu-

lar layers with one or two Lembert sutures so as to cover the perforation and unite the incision at the duodenal end for a short distance. Death ensued in only one of these patients, very suddenly within 12 hours after operation, and as previously mentioned (Death No. 4) was due to circulatory failure or probable overadministration of intravenous fluids. Significantly also, only two of the 13 patients received chemotherapy, one of whom was placed on penicillin and the other on a combination of penicillin and sulfadiazine.

It is our belief, therefore, that although the desirability of avoiding accidental perforation of the duodenum is not to be minimized, the complications customarily associated with this accident are not as grave as most surgeons fear. It may be mentioned with some reticence that it is the empirical belief of the senior author that not infrequently in such patients the convalescence is smoother, probably because all the fibers of the duodenal end have certainly been divided. The important point which needs no stressing is that the perforation be recognized and that having occurred, suitable measures be taken to effect closure.

A last point not frequently mentioned is the occasional occurrence of coffee-ground vomitus or tarry stools occurring in this illness either before or after operation. Tarry stools were noted in seven instances, and in six cases the patients had either bloody or coffee-ground vomitus which was positive for benzidine. Coffee-ground material and bright blood in the vomitus is reported by Donovan, usually as the result either of rupture of a mucosal vessel during the act of vomiting or from an associated gastritis. We agree with Donovan, and mention the occurrence only to point out that it bears no ominous import.

SUMMARY

Two hundred cases of pyloric stenosis subjected to pyloromyotomy during the years 1930 through 1947 are reported. The mortality rate was 2 per cent. The procedure recommended is done under ether anesthesia, employing a high rectus incision and silk closure. There were no eviscerations and three wound infections. The duodenum was entered accidentally 13 times, and was handled in each instance by simple closure with one or two Lembert silk sutures. In no instance do we believe that it contributed to increased morbidity or mortality.

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Proteins in Pregnancy

Rationing of food is not as great a factor in serum protein levels in pregnancy as dietary habit.

Stander gave 6.5 gm. per 100 cc. of blood as the average during pregnancy. My series of 377 cases averaged 5.95 gm. The highest serum protein level found was 7.2 gm. and the lowest was 4.5 gm. Only 52 per cent of my cases had a serum protein level of 6.0 gm. or above. Seventy-one cases or 19 per cent had a blood serum protein below the critical level!

The hemoglobin level was found to be intricately tied to the protein level, falling gradually as the serum protein level falls. This corroborates findings of Bethell, Youmans, and others. The hematocrit, or corpuscular volume, determination and red blood count were not appreciably affected. Edema of pregnancy is shown to vary in inverse proportion to the serum protein level.

An attempt was made to remove the sodium ion as a factor in the edema by salt deprivation for one week before edema was graded. However, salt being such a universal food constituent and human nature being what it is, salt probably created a small error in the series. Also, no way is as yet known to neutralize the electrolyte-like action of the high hormone levels found in pregnancy; nor, for that matter, the similar action of the adrenal hormones.

A group of 184 cases studied during food rationing was compared with 193 cases studied after food rationing was discontinued.

Only 52 per cent of an average group of American women had a total serum protein level that could be considered within normal limits.

Of this group 19 per cent had bodies dangerously depleted of proteins and were not good candidates to bear large families of strong, healthy children.

After elimination of all controllable factors, 8 per cent of the normal protein group had some edema, usually mild; 78.4 per cent of the group frankly deficient in protein had edema and a large percentage of these women had severe swelling.

Hemoglobin determinations were found to fall with the serum protein level.

Hematocrit determinations and red blood cell counts did not seem markedly affected.—John W. Worsham, M. D., San Antonio, Texas. *Texas State Journal of Medicine*, Vol. XLIV, No. 4, August, 1948.

The Etiology and Diagnosis of Subphrenic Abscess

HAROLD T. GROSS, M.D.

THE discovery of an undiagnosed, easily treated subphrenic abscess at the post-mortem table is still of sufficient occurrence to justify analysis of the etiology and to consider carefully the existing signs for earlier diagnosis. Such discoveries time and time again attest to the fact that the diagnosis of subphrenic abscess is difficult and frequently overlooked. This accounts in part for the high mortality of 20 to 40 per cent in surgically drained cases, and of 90 per cent in those without drainage. Perhaps the chief reason for not recognizing this condition is the failure to consider the possibility of its existence. In any case of persistent elevation in temperature of unexplained origin and a history of sepsis, a subphrenic abscess should be considered. In 84 per cent of the cases the primary cause is an intra-abdominal lesion, with the greatest number occurring postoperatively. Occasionally, the subphrenic area is involved at the time of surgical intervention but is not recognized. In other instances it is the result of contamination at the time of operation. If, after an abdominal operation for a suppurative process, the postoperative course is not smooth, even if weeks have elapsed, a subphrenic infection must be ruled out. The mortality of this condition will be appreciably reduced if subdiaphragmatic abscess is recognized early and drained immediately. Early recognition is not difficult if this complication is kept constantly in mind and particular attention is paid to repeated evaluation of the clinical signs and symptoms, careful physical examination, and the application of prolonged and repeated fluoroscopic and X-ray studies.

ETIOLOGY

Subphrenic abscess is rarely a primary condition. Its presence almost always suggests a suppurative process elsewhere in the body and generally one within the abdomen. The causes of subphrenic abscess can be classified into six essential groups resulting from:

1. Direct extension (contiguous organs).
2. Distant extension (appendix, pelvis, etc.).
3. Rupture into the subphrenic area.
4. Retrograde lymphatic extension.
5. Metastatic infection (furunculosis, septicemia, etc.).
6. Direct implantation.

1. Direct Extension from the Peritoneum and Contiguous Organs: The most frequent exten-

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sion of infection into the subdiaphragmatic spaces occurs from peritonitis. This is especially true if the patient is tilted into the Trendelenburg position, as dependent drainage will have a tendency to take place into the subphrenic area, rather than away from it. An additional factor is the presence of a negative pressure in the subphrenic region during respiration which serves to draw infection upward.

Contiguous extension also occurs from renal infections. Such an infection first extends outside the kidney as a perinephritic abscess, then extends upward and reaches the bare area over the right lobe of the liver. Likewise, any extramural spill from an organ intimately related to this area may cause a localized abscess in the vicinity of the perforation, in the lesser peritoneal sac, or in the sub-diaphragmatic area. Such extensions may occur from perforation of a liver abscess, perforation of the stomach, duodenum, or gallbladder, and extension of an osteomyelitis of the lower dorsal or upper lumbar vertebrae.

2. Distant Extension: The most common cause of a subphrenic abscess arising from distant extension is that following infection of the appendix. This may be produced in several ways as follows:

(a) As a result of a generalized peritonitis secondary to a ruptured appendix.

(b) As a result of the rupture of an abscess of the liver following an infected thrombophlebitis arising from the appendix.

(c) Through infection of the posterior cellular spaces. The work of Aschoff has demonstrated that four layers of lymphatics are present in the wall of the appendix, and all drain into the meso-appendix. Monroe has shown that infection in the lymphatics of the meso-appendix may be carried back to the retroperitoneal cellular space behind the ascending colon and in front of the kidney to the subdiaphragmatic spaces. In addition, the possibilities of a subphrenic abscess are greatly increased if the appendix is under

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the liver, retrocecal, or associated with an abscess. Occasionally, in the removal of an inflamed appendix which is adherent to the posterior parietal peritoneum, the appendix is torn away from its attachments leaving a piece of infected material behind, or a part of the surface of the peritoneum is pulled away with the appendix. In either case a raw and infected surface is left through which organisms may reach the retroperitoneal cellular spaces and lymphatics, and the subphrenic spaces.

(d) **Via the lymphatics:** In 1903, McCallum and Clarke working independently found that the lymphatics of the general abdominal cavity tend to concentrate below the diaphragm. Lemon and Higgins have also shown that substances injected into the peritoneal cavity will frequently appear in the thorax via the lymphatics. Cunningham later pointed out that before this material appears in the thorax there will be an accumulation of the injected material below the diaphragm. Truesdale explains this lymphatic extension thus: "The bacillus-laden lymph passes from the appendiceal abscess to the appendicular nodes which then empties into the lymphatic trunk following the superior mesenteric vein which in turn empties into the portal vein. From here the lymphatics extend along the line of attachment of the falciform ligament. The lymphatics then pass to the area above the liver where the infection may localize and form a subphrenic abscess."

(e) **By way of the paracolic gutter:** Along the ascending colon the peritoneal reflections form a natural fold or channel along which infections in the vicinity of the cecum may extend upward along the lateral surface of the liver to involve both the right subhepatic and suprahepatic spaces.

3. Rupture Into the Subphrenic Area: Any pre-existing localized infection near the subdiaphragmatic area may rupture into it. A liver abscess or an empyema perforating the pleura and diaphragm, may do this.

4. Retrograde Lymphatic Extension from the Thorax: In subphrenic abscess secondary to empyema, pneumonia, or lung abscess, the thoracic lymphatics which communicate with the subphrenic area become infected. As a result of the lymphatic blockage, retrograde stagnation and infection take place which extends as far back as the dilated lymphatics on the inferior surface of the diaphragm. The lymphatics then become increasingly distended with the infected material until they rupture, causing an infection in the subphrenic area.

5. Metastatic Infection: In this mechanism of etiology it is presupposed that an infection exists which finds its way into the blood stream and thence to the subphrenic area by way of the

circulation. Such infections include furunculosis, osteomyelitis, septicemia, etc.

6. Direct Implantation: The infection is carried directly into the subphrenic area by trauma such as a stab or gunshot wound of the lower part of the thorax or the upper abdomen.

LOCATION

The term "subphrenic" refers not alone to the region immediately below the diaphragm, but includes as well an area that extends as far down as the transverse colon and the transverse mesocolon. In the presence of infection these structures, and the greater omentum, may adhere firmly to the anterior abdominal wall and limit the downward extension of the inflammatory products. The bulk of this space is occupied by the liver which, with its peritoneal connections, serves as the focal point for division of this area into anatomically recognizable spaces. The falciform ligament of the liver further divides this area into right and left segments each containing anterior and posterior spaces designated either suprahepatic or subhepatic.

The most frequently involved is the right posterior subhepatic space. This common involvement is based upon its greater accessibility to inflammatory exudate coursing upward from the iliac fossa along the right paracolic gutter. This route of extension from the appendix may also involve the right anterior suprahepatic space by going up over the liver. A ruptured gallbladder or duodenal ulcer frequently involves the right subhepatic space, whereas infection following surgery of the gallbladder will quite often involve the right suprahepatic space. This difference has been explained by the fact that the infection does not occur in the dependent right inferior space, as would be expected because it is this area which is drained at operation.

A left subphrenic abscess most commonly results from an intra-abdominal focus, the most frequent being perforated ulcer of the stomach or duodenum. A ruptured anterior gastric ulcer or a rupture of the gallbladder may involve the left anterior subhepatic space. A perforated posterior gastric ulcer will involve the left posterior subhepatic space which is the lesser peritoneal sac. Left sided lesions may also arise from direct extension from the pelvis and appendix. Barnard has explained this by the existence of a pathway which leads from the recto-vesical or recto-uterine pouch over the left sacro-iliac joint to a gutter formed by the vertebral column on the right, the descending colon on the left, and the mesentery behind. This gutter directs pus up to the duodeno-jejunal flexure where it passes forward along the splenic flexure to reach the left subphrenic spaces. Pus may also reach the left side from the pelvis by following along the left lateral

gutter, i.e., between the colon medially and the lateral abdominal wall.

DIAGNOSIS

A. General Considerations: Perhaps the chief reason for not recognizing this condition in many cases is the failure to consider the possibility of its existence. In any case of persistent elevation in temperature of unexplained origin and a history of sepsis, a subphrenic abscess should be considered. In the early or subacute case the onset is usually insidious with minimal symptoms such as malaise, fatigue, anorexia, pallor, vague pains at the site of the abscess or a low grade fever. As the condition progresses the temperature and pulse become elevated and tend to assume a septic course. At a still more advanced stage the patient may exhibit a loss of weight, respiratory distress, short spasmodic bouts of cough, and occasionally hiccough. The white blood count may rise to 20,000 with 85 per cent polys, and sometimes is elevated to as high as 40,000. On inspection in some cases one may find an acutely sick individual with a flush, a warm moist skin, and an anxious expression, breathing rapidly with restricted respiratory excursions of the chest on the side corresponding to the abscess. The usual picture, however, is generally obscure with no obvious clinical or physical signs, and the great majority of cases are diagnosed predominantly upon the fluoroscopic and X-ray findings alone.

B. Physical Signs: Inspection of the chest and abdomen reveals no recognizable signs which suggest the presence of an abscess in the majority of cases. Palpation sometimes reveals tenderness over the twelfth rib posteriorly or just below the costal margin anteriorly. When gas is present, percussion may yield the classical four areas of altered resonance which are, from below upward: 1) Dull—due to liver; 2) resonant—due to gas in the abscess; 3) dull—due to collapsed lung; and 4) resonant—the normal lung resonance.

C. Abdominal Manifestation: Since most subphrenic abscesses are secondary to an intraperitoneal suppurative process, one usually looks first to the abdomen for the cause of a patient's failure to improve. If abdominal signs are present there may be noted a restriction of respiratory movements on the affected side. In a few cases tenderness may be present to deep palpation below the rib margin. Occasionally, the liver may be displaced downward in the presence of a large suppurative process in the suprahepatic spaces. Generally, the absence of definite, clear-cut, abdominal findings is to be expected in the average case. In some advanced cases, however, there may be a palpable or visible mass in the right upper quadrant but this is not generally observed.

D. Thoracic Manifestations: Restricted respira-

tory movements, pleural pain, and elevation of the diaphragm are more common diagnostic findings in subphrenic abscess than are the expected abdominal findings. Diaphragmatic pleural pain and irritation may cause a short, spasmodic cough, and an increase in the respiratory rate. Tenderness occasionally is found along the tenth rib anteriorly or along the eleventh and twelfth ribs posteriorly. Not infrequently a friction rub may be heard at the base of the thorax due to the rubbing of the diaphragm against the inflamed upper surface of the liver. Rales may be heard at times at the lung base in the area of compression atelectasis from an elevated, fixed diaphragm. Altered thoracic signs frequently are the first indications of a subdiaphragmatic suppurative process.

E. Roentgenographic Studies: The final and conclusive diagnosis of subphrenic abscess is reached by careful X-ray and fluoroscopic studies in almost every case. The most characteristic sign is elevation of the diaphragm.

Fixation of the diaphragm, regardless of the degree of elevation, is pathognomonic of subphrenic abscess, and an elevated, fixed diaphragm is conclusive. In most cases there is a variable amount of fluid in the pleural cavity on the affected side or an area of compression atelectasis of the lower lobe along the raised diaphragmatic border. Occasionally, a fluid level with a gas bubble above may be seen below the diaphragm which represents gas-forming organisms in an abscess cavity. In those cases in which only suggestive findings are present, additional evidence may be obtained by the introduction of barium into the stomach and duodenum. Varying degrees of distortion of these structures such as flattening of the superior border of the duodenum or a filling defect of the lesser curvature will often outline the exact position of a suspected abscess. Roentgenographic studies of the lumbar spine and the surrounding area are also often of additional aid. The most frequent finding is a partial or complete obliteration of the psoas muscle shadow on the affected side. There may be noted a scoliosis of the spine with the concavity toward the side of the abscess. The liver and kidney may be depressed, and the liver edge may lose its sharp contour. Prolonged and repeated fluoroscopic and X-ray examinations are usually necessary in the doubtful cases.

F. Aspiration: Aspiration has frequently been recommended as a diagnostic adjuvant in subphrenic abscess. Most authors condemn this procedure. In Hochberg's series of 139 cases he says the three cases in which it would have given valuable information no pus was obtained, although surgical intervention soon after the aspiration revealed pus. Overholt and Donchess condemn aspiration and report 7 negative aspira-

tions in 21 cases of proven subphrenic abscess. If aspiration fails to reveal pus, it does not rule out the presence of a purulent collection. In fact, one may be more in a quandry as to the diagnosis after a negative tap than before the aspiration was instituted. Although most investigators condemn this procedure, undoubtedly there have been cases in which aspiration has been of distinct value.

TREATMENT

Drainage of a subphrenic abscess can be safely accomplished only by either an extrapleural or extraperitoneal approach. Any other method results in an excessively high mortality. Anterior abscesses are drained extraperitoneally just below the anterior costal margin. Abscesses located posteriorly are drained by an extrapleural approach after resection of the twelfth rib and opening the abscess through a transverse incision in the rib bed opposite the transverse process of the first lumbar vertebra. In these procedures careful attention is necessary to prevent soiling the pleura or peritoneum which would result in the undesirable complications of empyema or peritonitis.

SUMMARY

1. The term "subphrenic" when applied to subphrenic abscess not only designates the area immediately below the diaphragm but also includes the large area extending down as far as the transverse colon and transverse mesocolon and contains a number of anatomical spaces which are important in their relationship to infective processes and abscess formation.

2. The primary lesion producing subphrenic abscess occurs in the abdomen in about 84 per cent of the cases, and the appendix, stomach and duodenum, and the liver and biliary passages constitutes 65 to 75 per cent of all the sources of the infection.

3. Most subphrenic abscesses occur on the right side with the most frequently involved spaces the right anterior suprahepatic, and the right subhepatic spaces.

4. Most cases of subphrenic abscess reveal a minimum or no physical signs and are diagnosed only by a repetition of fluoroscopic and X-ray examinations.

5. Altered pulmonary signs and chest X-ray findings are frequently the first indications of a subdiaphragmatic suppurative process.

6. Left subphrenic abscess occurs less often than on the right, presents a more difficult problem of diagnosis, generally carries a poor prognosis in spite of adequate treatment, and is associated with a considerably higher mortality.

7. The general mortality of subphrenic abscess is over 90 per cent without drainage, and about 20 to 40 per cent with surgical drainage. Early diagnosis is of the utmost importance and should

be followed by adequate extrapleural or extraperitoneal surgical drainage.

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Contraindications to Early Ambulation

No discussion of early ambulation would be complete without a consideration of possible contraindications. Failure to recognize that not all patients can be ambulated early has probably led to the abuse and disuse of this program in the past. Each patient should be individually evaluated, and if any of the following extenuating factors are present, final judgment may well be to defer ambulation.

1. Shock: hypotension is aggravated by motion and the erect position.

2. Hemorrhage: because of the attendant shock and fear of encouraging more bleeding with motion.

3. Generalized peritonitis: because of the pain, distention, and sepsis.

4. Unrelieved intestinal obstruction: because of the distention and the resultant tension on wounds.

5. Pulmonary infection: because of tachycardia, dyspnea, toxemia.

6. Wound evisceration or extensive wound infection: tensile strength of wound is diminished.

7. Severe toxic states: irrational states such as are seen in thyroid crises, sepsis.

8. Cardiovascular complications: ambulation would add to the load of a burdened myocardium.

9. Extreme debility: nutritional deficiencies.

10. Severe anemia: cerebral anemia aggravated in the erect posture.—Karl A. Meyer, M. D., et al., Chicago, Ill. *Minnesota Medicine*, Vol. 31, No. 8, August, 1948.

Endocrine Aspect of Malignant Tumors

GRAY H. TWOMBLY, M. D.

PERHAPS one of the most significant advances in our present-day conception of cancer is the realization that certain malignant tumors may be made to regress by various changes brought about in the physiology of the patient's body, by "humoral alterations," if one wishes to so designate them. Until a few years ago the only methods of affecting cancer that seemed to offer any hope were various agents causing local tissue removal or destruction—radical surgery, chemical or thermal cauterization, or the local use of roentgen or gamma ray therapy. These are still our main reliance and probably our only methods of permanent cure. But with the papers of Huggins¹ and his coworkers showing the marked temporary changes which could be produced in metastatic cancer of the prostate by castration, a new concept has grown into our thinking, that perhaps it may be possible to bring about permanent regression of cancer by changing the hormone balance in the patient's body.

TEMPORARY IMPROVEMENT

Huggins in his latest report² on the results of orchiectomy on cancer of the prostate in man says that of his first twenty patients treated in this fashion, four are still alive and free of disease, while one is alive with slowly advancing carcinoma. The follow-up on these patients is from six and a half to eight years after operation. Nesbit and Plumb³ record 75 cases treated by orchiectomy, with 66.6 per cent dead at the end of four years. Fifty cases treated with stilbestrol had a shorter follow-up period, but at the end of two years, 12, or 24 per cent, were dead. At the same follow-up time, 37.3 per cent of the cases treated by orchiectomy and 69.4 per cent of 781 cases treated in other non-endocrine ways were dead.

Our own experience has not been so favorable. Of 34 cases treated primarily by orchiectomy,⁴ 29, or 85 per cent, are dead, four are alive five years or more, and one patient was lost track of at the end of four years. The average duration of life after orchiectomy was eighteen months.

While the ultimate prognosis in these men is not good, the immediate changes effected are often most striking. In the first case observed by us, an area of metastatic carcinoma in the head of the right femur showed marked produc-

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tive and destructive changes in the bony structure. A year after orchiectomy these changes had completely regressed and there had been a very marked return of the bone toward the normal picture. In another instance, a large recurrent mass in the scar of a suprapubic prostatectomy regressed so completely that it was no longer palpable. These are just two examples of many that have been observed. They force one to the conclusion that while orchiectomy or stilbestrol therapy may produce few definitive cures of carcinoma of the prostate, they do cause remarkable temporary changes in a large proportion of such cases, and these changes are frequently clearly demonstrable by physical or X-ray examination and are not confined to decrease in pain and a feeling of well-being, subjective symptoms, appreciated only through the senses of the patient and notoriously unreliable.

IMPORTANCE OF OBJECTIVE TESTS IN CANCER THERAPY

Huggins' contribution was not made because he was the first to think of castration as a method of treating tumors of the prostate. This had been done already by White⁵ as early as 1893. Rather it was because he took advantage of the quantitative estimation of the serum acid phosphatase as an objective test to indicate what was happening as a result of castration or endocrine therapy.

It is often the lack of an objective test, showing clearly and easily what is being accomplished by a given form of therapy, which delays or prevents new medical discoveries. When one relies on the clinical course of the disease, relief of pain frequently follows almost any form of therapy applied with sufficient faith and regularity. On the other hand, both doctor and patient often get discouraged when a type

⁴ Presented before the Section on Medicine at the annual meeting of the Ohio State Medical Association at Cincinnati, March 30-April 1, 1948.

of treatment which has seemed to work well in one individual fails to produce the desired result in the next three or four.

An excellent example of the difficulty of finding new and useful methods of treating cancer without anything but the clinical course of the patient to go by is given by the history of androgenic therapy for breast cancer at the Memorial Hospital. In 1940, Farrow and Woodard⁶ began to treat advanced mammary cancer cases with injections of testosterone propionate. Thirty-three patients with skeletal metastases were given doses of 5 to 25 mg., one to three times a week for ten or twelve doses. In addition, three patients were treated for short periods with 50 to 75 mgs. of testosterone a day for totals of 475 mgs., 400 mgs., and 500 mgs. They concluded from their studies that "testosterone in large doses exerts a stimulating rather than an inhibiting effect on the growth of metastatic mammary carcinoma."

Subsequently the late Dr Jules Abels⁷ treated a number of patients with carcinoma of the breast with large amounts of testosterone. He came to the unpublished conclusion that such therapy had no beneficial effect on breast cancer.

The thought that testosterone ought to inhibit the growth of breast cancer died hard however and some chance observations on patients treated by an unknown remedy outside the hospital suggested a further trial of testosterone in larger and more prolonged dosage. Finally, in 1946, Adair and Hermann⁸ reported 11 patients who received doses varying from 50 to 200 mgs., two or three times weekly for several months. Four of these showed striking improvement. In three, bone metastases recalcified and in one there was temporary regression of an extensive primary tumor.

RESULTS OF HORMONE THERAPY IN CANCER OF THE BREAST

With these observations as a "sheet anchor to windward," many patients have been treated subsequently with great and at times almost unbelievable success. One woman comes to mind particularly who had so much destruction of her left humerus that she had a pathological fracture and a flail arm. Radiographs showed a mere shell of bone. Under testosterone the entire bone recalcified, the fracture united, and the arm became painless and usable.

Enough experience has accumulated so that it can now be said that about 28 per cent of bone metastases from cancer of the breast will respond to testosterone therapy,⁹ at least temporarily. Metastases to other sites do not seem to behave so favorably. Of 28 cases with lymph node metastases, only three regressed. Twelve cases of lung metastases showed three favorable responses. The primary carcinoma in

the breast does not seem to respond at all to testosterone therapy.

In 1944, a group of investigators in England following the ideas of Hadow treated advanced cancer of the breast with stilbestrol.¹⁰ They observed spectacular healing of the primary tumor in one of 14 patients so treated. In this country, Nathanson¹¹ has extended this research greatly and has pointed out that the favorable results occur in women past the menopause, whereas estrogens in young women with breast cancer seem apt to stimulate rather than depress the growth rate. At the Memorial Hospital, 9 out of 32 cases with skin recurrence or metastases showed improvement under stilbestrol or ethinyl estradiol therapy.⁹ This is again about 28 per cent. Occasionally the results produced are quite striking.

In young women surgical or radiation castration may produce unequivocal evidence of the healing of bony metastases. This was first pointed out by Beatson in 1896.¹² A statistical study of the effect of radiation castration in a large group of women was made by Dresser in 1936.¹³ The evidence of bone healing in some of his cases is unquestionable.

CANCER OF THE MALE BREAST IMPROVED BY CASTRATION

A fifth example of the control of inoperable cancer by changes in the hormone environment, and perhaps the most successful of all, is provided by the studies of Treves, Abels, Woodard and Farrow¹⁴ on the effect of castration on cancer of the male breast. They believe that about half the cases so treated show marked improvement and that cancer so controlled remains inactive for long periods.

In brief, then, proof can be produced that cancer of the prostate and cancer of the breast in both men and women in some cases can be made to regress by hormonal changes in the patient's body. So far, the regression seems to be usually only temporary.

STIMULATION OF CANCER GROWTH MAY FOLLOW HORMONE THERAPY

It should not be overlooked that the opposite effect, namely stimulation or reactivation of dormant cancer, may occur occasionally. In at least one of the three cases reported by Farrow and Woodard,⁶ the growth of bone metastases was thought to have been increased by testosterone therapy. Huggins records stimulation of the growth of prostatic cancer by similar means.¹⁵ Nathanson¹¹ reports stimulation of the growth of breast cancer in young women with stilbestrol.

Gardner¹⁶ has recorded one of the most interesting observations in this connection in some experimental mice implanted with a "Leydig-cell" testicular tumor. The cancer had been produced

by injecting male mice of the A strain with estrogens over a long period of time. The tumor was transplantable, but only to estrogenized animals of the same strain. If transplants were made to non-estrogen treated animals and allowed to stay for as long as 73 days, no tumor growth took place and no clearly identifiable tumor cells could be found on killing and skinning the animals. If these animals were injected with estrogens, however, instead of being killed, the dormant transplants began to grow at once, increased in size as fast as new transplants in estrogenized animals, and soon killed their hosts.

We have here a suggestive parallel to occasional cases seen in human beings. A cancer of the breast in a woman may appear to have been completely removed for several years. The patient becomes pregnant and the change in hormone stimulation seems to re-awaken dormant cancer cells in her body which grow with vigor and soon bring about her death. A number of such cases have been recorded by Trout,¹⁷ who says that of fifteen patients becoming pregnant after radical mastectomy for cancer of the breast, thirteen showed reactivation of the malignant process.

Cancer of the breast and cancer of the prostate can be made to regress or can be stimulated to renewed or increased growth by hormonal changes in the body. Were we to understand more fully how these changes cause their effects, the desired regressions might be prolonged, occasional instances of stimulation of cancer growth might be avoided, and further insight into the cause and cure of cancer in general might be obtained. Studies of the metabolic pathways of estrogens and androgens in normal and cancerous men and animals are needed.

KNOWLEDGE OF HORMONE METABOLISM MAY BE OF GREAT CLINICAL IMPORTANCE

Perhaps the most ambitious work being carried on along these lines is that of Dobriner and Lieberman and their co-workers at the Memorial Hospital.¹⁸ These investigators have spent several years developing methods whereby more than 42 steroids have been isolated and characterized. One of these, Δ^9 etiocholenol-3 α -one-17, is worthy of particular mention because it was found to occur in the urine of patients with cancer of the prostate and breast, but not in that of normal individuals. It was found in the urine of two patients with hypertension and a patient with Cushing's disease. The occurrence of this ketosteroid in these cases suggests it to be due to some abnormality of adrenal physiology. Its presence in cancer urines and not in normal ones suggests again a connection between cancer and hormones. Of particular interest were the observations made by

these investigators on the urine of a member of their laboratory staff who showed the compound in her urine several years before the appearance of a clinically evident carcinoma of the breast. With radical mastectomy and subsequently no evidence of recurrence, the amount of this metabolite has slowly decreased but has never entirely disappeared.

Whether Δ^9 etiocholenol-3 α -one-17 is a product of certain kinds of cancer and conceivably could serve as a cancer test, or whether it is the result of a deranged endocrine metabolism which in turn is responsible for the production of cancer, is a question which must await more data by these investigators for its solution. Of particular interest would be studies of the steroid excretion pattern, including etiocholenolone, in patients with cancer of the prostate or breast before and during tumor regression brought about by changes in the hormone balance and with recurrence. These have not been recorded as yet.

Finally, there is a very promising field for study of cancer and hormones in the use of estrogens labelled with radioactive isotopes.¹⁹ In our laboratory we have made dibromestrone by brominating equilin with radioactive bromine 82. This material is found to be excreted promptly in the bile after injection. It can be reabsorbed from the bowel and so undergoes a biliary portal circulation. Ultimately, in the rabbit at least, about equal quantities are excreted in the bile and in the urine. Similar labelled steroids can be made and can be used readily for the study of estrogen metabolism in cancerous and non-cancerous men and animals.

Finally, the possibility that steroids may be selectively localized in their target organs—uterus, breast, or prostate—is a most intriguing idea. If it could be shown ever that estrone or testosterone is concentrated in these structures the way iodine is in the thyroid gland, then the possibility of treating cancer of the breast, uterus or prostate with radioactive hormones would become apparent.

The thought in the first paragraph of this paper that perhaps cancer may be cured by the proper changes in its hormone environment has led us to build a scientific castle in the air, the possible future cure of cancer in metastatic inoperable areas with radioactive hormones—a dream, to be sure, but one that does not seem so entirely beyond attainment as it did a number of years ago.

SUMMARY

1. The treatment of cancer of the prostate by orchiectomy or stilbestrol and of cancer of the breast by testosterone or stilbestrol or, when it occurs in men, by castration, has proved that definite regression can be produced in a

certain percentage of patients suffering from these kinds of cancers by endocrinological means.

2. These changes appear to be temporary though often striking. Were we to understand thoroughly the details of the metabolism of the steroids in such cases, regression might be enhanced or prolonged.

3. Steroid hormone metabolism may be studied by urinary extraction and isolation methods or by the use of injectable steroids labelled with radioactive isotopes.

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In subjects with chronic illness associated with debilitation, the output of urinary corticoids may be low or within the lower range of normal. If sufficient protein and calories can be administered, a positive nitrogen balance and eventual gain of weight can always be established in these conditions.—T. H. McGavack, M.D., & David Schwimmer, M.D., N. Y. C., N. Y. State Jr. of Medicine, Vol. 48, No. 16, August 15, 1948.

Gynecology and Geriatrics

It is little wonder that our predecessors wrote but little regarding gynecologic problems in elderly women. In 1890, the average span of life for a woman was 35 years. By 1930, this average life span had increased to 62.8 years, which represents an increase of 27.8 years in a 40-year period. In 1946, the fiscal report revealed the average life of American women to be 64.2 per cent, which represents an increase of over 50 per cent since the first report. Approximately eight per cent of our population are 60 years and older and slightly more than half are females which may be a modern explanation for the old adage "that woman always gets the last word."

In which period of life can it be said that old age begins for woman? We must consider the starting point of old age the period in which the first ovarian endocrine insufficiencies manifest themselves, characterizing the menopause. Much has been written concerning the management of the latter syndrome and all modern physicians are familiar with its variety of symptoms and their management. It is the purpose of this paper to offer a brief discussion of the more common gynecologic problems which have been seen concerning the management of patients 60 years and older. Post-menopausal bleeding, genital prolapse, pyuria, and tumors constitute over 80 per cent of these problems. The psychologic management of this group of patients is most important and at times difficult. Women of this age notably are shy, modest and timid. It is their habit to stay away from a physician as long as possible, preferring not to submit to genital examination and frequently do so only because of fear of cancer or upon insistence of relatives.

It is necessary to better understand the symptomatology of this group of patients that one has an accurate knowledge of the normal physiology and anatomy associated with this chronologic period. In elderly women organs and tissues have undergone physiological involution, and atrophy is the normal phase. Notably when ovarian secretion is eliminated, either by the climacteric or by surgical removal of the ovaries, actual senescence occurs in the tissues of the vulva, vagina, uterus, and mammary gland.—Gerald Rogers, M.D., Oklahoma City, Okla. Jr. of Oklahoma State Medical Assn., Vol. 41, No. 8, August, 1948.

The Treatment and Cure of Bichloride of Mercury Poisoning By the Use of Peritoneal Lavage

JOHN L. TOTH, JR., M.D., and H. C. KING, M.D.

THE possibility of effective treatment of toxic nephrosis caused by mercury bichloride was recognized early by investigators. Work by Lomholt, later by Sollmann, shows that this process is reversible. The majority of patients who survive the original shock period run a definite well defined course, i.e., degeneration of tubal epithelium up until the seventh to ninth day and regeneration from then on. The majority of these patients usually expire around the sixth to tenth day of uremia. The clinical course roughly goes through three stages: polyuria-anuria-polyuria. The anuria is not caused by mechanical obstruction or suppression of glomerular function as believed by earlier investigators, but according to the work of Richards and Schmidt by "decrease in the formation of urine by such a kidney is obviously not due to the suppression of glomerular function. It may be due to the non-selective diffusion of tubule contents back into the blood stream resulting from the osmotic drawing power of blood plasma proteins together with the abolition by the poison of the normal selective impenetrability of the tubule wall." From this we notice that our problem is to combat the anuria-uremic stage until kidney function again sets in—a problem of removing from the body "uremic substances" which are incompatible to life. This also explains the failure of our previous therapeutic measures, i.e., force fluids and kidney decapsulation.

Clinical trials did not bear out the use of sodium formaldehyde sulfoxylate. According to Hull and Monte the same percentage of patients developed toxic symptoms after the institution of the use of sodium formaldehyde sulfoxylate as before its use. This is probably due to the rapid absorption of mercury bichloride, probably the same holds true in British Anti-Lewisite.

Ganter, in 1923, recognized the peritoneum as a huge dialyzing membrane and the possibility of removing waste products through it. Balazs and Rosenak² in Vienna were the first to try this method in 1927 on a human being following mercury bichloride poisoning. This method was the washing out of the peritoneal cavity with two liters of hypotonic solution through a trocar. This procedure was not successful in saving life but he proved that it is possible to wash out waste products in this manner. Rhoads also tried this method in two cases, one of chronic nephritis and one of chronic glomerular-nephritis

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—both expired. The nature of these two cases make the possibility of this procedure to be successful very questionable. The research work of Rosenak and Siwon, von Jeny, Balazs and Rosenak, Bliss, Kastler and Nadler, Haam and Fine, Seligman, Frank and Fine³ demonstrated on ureteral ligated dogs that significant amounts of "uremic substances" could be removed from the body fluids by peritoneal irrigation with temporary prolongation of life. These were all cases of intermittent injection and withdrawal of fluid.

Fine, Frank, and Seligman⁴ in 1946, were the first to introduce a continuous drip method of peritoneal lavage. Since then this method was used in 16 cases in the literature out of which nine survived. Of these, six were incompatible blood transfusion—out of six, three survived; two cases of sulfathiazole intoxication—both recovered; one mercury bichloride—died. Three cases of ureteral obstruction—two recovered and one died; one case of carbontetrachloride with recovery.

The main difficulties encountered are:

1. The possibility of peritonitis—combated with the use of penicillin and streptomycin.
2. The possibility of clotting of the irrigation mechanism—use of heparin.
3. Irrigation fluids to be used—the choice of fluid is very important to maintain body fluid and electrolyte balance. Originally Thyrode's solution was used which is a modified Hartman's solution with soda bicarbonate and dextrose. This in practically all the cases lead to edema. We decided to use intermittent Hartman's and 5 per cent glucose in saline solution depending on blood chemistry. We also decided to combat albumin-

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emia and acidosis by intravenous method, i.e., the use of amigen, $\frac{1}{6}$ molar lactate solution, and soda bicarbonate intravenously. It is of great importance to suit the use of irrigation fluids to body fluid chemistry.

TECHNIQUE

Our technique agreed with the majority of cases:

1. Mushroom catheter in left upper quadrant-Poole drain in right lower quadrant.
2. No bacteria filter (Odell and Ferris, Mayo Clinic).
3. Room temperature of fluids attached to intravenous sets.
4. Heparin for one day only—0.2 mgm. per liter of irrigating fluids.
5. Wangensteen suction with moderate suction.
6. Fluids at one and one-half hours per liter.

From thus simplifying the techniques it becomes possible for smaller general hospitals to institute this method of treatment.

Following is the case of a patient successfully treated with peritoneal lavage.

CASE HISTORY

M. C., a 20-year-old white male patient was admitted to the hospital about twenty minutes after taking eight one-half gram tablets of mercury bichloride. The patient claims he vomited once about five or ten minutes after taking the poison; he does not know whether or not there were any whole tablets in the vomitus. Vomitus was not bloody. Stomach lavage was instituted immediately upon admission with a 5 per cent solution of sodium formaldehyde sulfoxylate—at this time no traces of mercury bichloride tablets could be found in the vomitus. The intravenous treatment of sulfoxylate was started. Negative family and past history. Physical findings were negative.

I. Pre-peritoneal Irrigation Course. (First to Fifth Hospital Day)

The patient was continually vomiting small amounts of blood-tinged gastric secretion. He developed abdominal cramps with bloody stools on the fourth day, and the urine at first was of high specific gravity; large amounts with four plus albumin, later becoming lower in specific gravity with no albumin or cellular elements. On the fifth day the total output was about 300 cc. with a specific gravity of 1.005 and no albumin or cellular or cellular elements. All during this time the patient was receiving 4000 cc. of intravenous fluids daily. The blood urea nitrogen was 28.5 and the creatinine 10.6. At this time the CO_2 combining power was 31.5; blood chloride 347.5 mgm. per cent total protein 5.65; albumin 2.67; globulin 2.97; and the albumin-globulin ratio 1.08.

The patient was lethargic, complaining of sleepiness and abdominal cramps. At this time, peritoneal irrigation was decided upon.

II. Peritoneal Irrigation Period. (Fifth to Eleventh Hospital Day)

Under local anesthesia with one per cent novocain, a number 12 mushroom catheter

was inserted into the abdominal cavity in the left upper quadrant through a small incision. A Poole drain was placed into the right lower quadrant using the same technique. The mushroom catheter was attached to an intravenous set using alternatively a 5 per cent glucose and saline solution with Hartmann's solution. Each 1000 cc. of fluid contained 0.2 mgm. of heparin and 25,000 units of penicillin. The perfusing fluid was set at a rate of one liter per one and half hours. The Poole drain was attached to a Wangensteen suction set under moderate suction and this process was carried on for six days. At no time did we have any trouble with the lavage flow except at times when the Wangensteen suction did not work because of the tubing becoming entangled. The lowest amount of lavage fluid used on any one day was 10.160 liters on the first and the highest amount was 22.800 liters on the last. At no time did the patient develop enough abdominal tenderness which could be attributed to peritonitis, but on the fifth day streptococci and staphylococci could be cultured from the irrigation fluid. From this day the patient was given 50,000 units of penicillin intramuscularly as well as the fluid penicillin. The highest temperature recorded was 38.8°C . for one day—the fifth.. The rest of the time the temperature was normal. At no time did the patient develop lung edema or extremity edema.

During the six-day period we used 88 liters of intake perfusing fluid—the output being 97 liters. This nine-liter excess came from the intravenous fluids of which we gave 2000 cc. daily. The type of intravenous fluid used was mainly aimed at combating acidosis, the success of which is reflected by the fact that the CO_2 combining power which came down to 17.6 on the third irrigation day steadily rose thereafter. To achieve this purpose we used $\frac{1}{6}$ molar lactate solution with 7.5 grams of sodium bicarbonate in each 1000 cc. daily. The patient also received 1000 cc. of amigen daily to combat proteinemia and reverse albumin/globulin ratio.

On the first peritoneal lavage day the urine output was 500 cc. of low specific gravity with no albumin or microscopic elements. Following this was a period of 36-hour anuria until the third lavage day when the patient urinated 260 cc. in twenty-four hours. This urine was also of low specific gravity, 1009-1011 with traces of albumin but no microscopic elements. The urine output from here on increased rapidly until the sixth day, the last lavage day, when it reached 2310 cc.—the specific gravity being 1010-12 with traces of albumin but no microscopic elements. On the first day of urination after the anuric period the urine urea nitrogen was 79.8 mg. per cent and the urine creatinine was 57 mg. per cent. At this time the blood urea nitrogen was 37.5 mg. per cent, the blood creatinine was 12 mg. per cent showing that the specific concentrating function of the tubules was returning. The urine urea nitrogen mg. per cent steadily rose with the amount of urinary output until the sixth day when it reached 420 mg. per cent leading to a 20.76 gm. of urinary urea output which is about twice as much as normal urea output, thus showing the rapid regeneration of tubule function. The increase in creatinine excretion was much slower (see Table).

The effectiveness of peritoneal irrigation as a mode of removing "uremic substances" can easily be seen by the table. In six days we

Table 1
Urea and Creatinine in Blood, Dialysate and Urine

Days	Blood		Dialysate				Total Fluid Intake		Urine		
	Urea Mgm. %	Creat. Mgm. %	Outflow Cc.	Total urea mgm.	Urea Mgm. %	Creat. Mgm. %		Output Cc.	Total urea mgm.	Creat. Mgm. %	Urea Mgm. %
4	28.5	8.6					4300	1000			
5	40.2	10.6					5000	500			
6	40.2	10.6	10,160	10,550	54	6.5	1900	240			
7	22.5	12.0	11,000	9,590	45	3.5	800	0			
8	37.5	12.0	21,090	25,890	55	6.6	3980	260	445	57	79.8
9			11,200	21,400	72	8.6	3900	625	2140	76	160
10	27.0	9.5	20,800	41,800	76	4.85	4100	1625	5350	28	154
11	48.0	7.85	22,800*	30,600	67	6.0	4100	2310	20762	42	420
12	32.5	7.20					3900	2950	30268	40	480
13	30.6	7.20					3400	4100	47389	46	540
14	66.0	6.05					3300	3800	54998	172	750
15	39.0	4.85					3700	3700			
17	25.5	2.0									
18	28.5	3.35									
20	17.5	0.85									
22	13.5	0.30									

removed 139.83 gm. of urea by this method. The lowest daily amount being the second day when we removed 9.59 gm., the highest on the fifth day when we removed 40.8 gm. This last figure is of very great importance when we remember that the normal daily kidney urea output is 12-15 gm. The prognosis of our therapy was placed on the blood creatinine values. This endogenous protein waste product gives a more reliable and true picture of the uremic state than does the blood urea nitrogen value. The creatinine value reached its highest level on the second and third lavage day being 12 mg. per cent. From here it shows steady decline reaching 7.85 mg. per cent on the sixth lavage day.

The patient during the lavage period became more alert, the persistent bloody diarrhea and vomiting subsiding. On the third lavage day he was placed on frequent feedings of milk and cream. On the last lavage day he was placed on a high protein, high carbohydrate, high vitamin low residue diet of frequent feedings which he tolerated well.

On the sixth day of lavage, due to the blood creatinine level showing a steady decreasing tendency, and the large amount of urinary secretion with returning specific tubular concentrating function (i.e., 420 mg. per cent of urine urea nitrogen), and also because of the increasingly uncooperative attitude of the patient, the irrigation was discontinued.

III. Post Irrigation Period (Eleventh to Twenty-Second Hospital Day)

The patient showed a steady improving clinical course. The temperature remaining normal, penicillin was discontinued on the fourth post-irrigation day. He tolerated his diet well with normal bowel habits, though at times he complained of griping gas pains. The patient was ambulatory the third post-irrigation day. The diuresis was satisfactory with the patient void-

ing daily over 3000 cc. of urine showing faint traces of albumin but no microscopic elements. The urine of the third post-lavage day reached a high in urine urea nitrogen concentration; namely, 750 mg. per cent with a creatinine concentration of 172 mg. per cent—a total of 54.99 gm. of urinary urea excretion thus denoting satisfactory tubular function. On the second post-lavage day the urine became acidic having been alkaline during the previous period. The highest specific gravity of urine was 1016.

The blood urea nitrogen and blood creatinine show a decreasing tendency with values of 13.5 mg. per cent blood urea nitrogen and 0.3 mg. per cent of blood creatinine, on the eleventh post-lavage day or twenty-two days after ingestion of poison.

To combat albuminemia the patient was on a high protein diet. Despite this he had an albumin/globulin ratio of 0.63 with a normal total protein the first post-lavage day and an albumin/globulin ratio of 0.42 with 8 mg. per cent total protein on the eleventh post-lavage day. At this time the cephalin-cholesterol flocculation was one plus in forty-eight hours, and the B.S.P. test was negative for one half hour. This albuminemia is in all probability due to albumin loss in the renal excretion plus an active liver-function lesion. The CO₂ combining power steadily rose, reaching a 46.2 combining power on the eleventh post-lavage day. The patient received supplementary parenteral vitamins B and C from the third lavage day. Due to the patient's uncooperative attitude and desire to leave the hospital, he was finally discharged on the eleventh post-lavage day or twenty-two days after admittance.

The patient is seen weekly at our out-patient department clinic and thus far has no complaints. Weekly total protein and albumin/globulin ratio determination show steady improvement—his last readings, three weeks

after discharge, indicate a normal total protein and an albumin/globulin ratio of 0.63. The patient is still maintained on a high protein, high carbohydrate, low residue diet with supplementary polyvitamins, and it is our aim to readmit him in about one month for more comprehensive renal function tests and blood chemistry.

COMMENT

In review, this case shows a possibility of the removal of "uremic substances" by peritoneal lavage through the period of tubular non-function until the return of tubular function—i.e., the time when the tubular epithelium regenerates and is able to carry out its specific concentration function. By peritoneal irrigation we recovered 139.83 gm. of urea in the dialysate—the highest being 41.8 gm. in one day. This roughly corresponds to the findings of Grossman, et al.,⁵ and Pearson.⁶ The output of urea roughly corresponds to the amount of lavage fluid used, though the possibility of increasing the amount of urea excreted by this method by increasing the amount of fluid used is very debatable, in as much as the patient is unable to tolerate an appreciable increase in the amount of perfusing fluid. It is of interest to note that though the amount of urea excreted and the amount of fluid used in this manner corresponds with the findings of Pearson and Grossman, et al., their blood urea nitrogen and non-protein nitrogen levels were much higher than ours. In Pearson's case the blood urea nitrogen ranged between 158 and 224 while Grossman had non-protein nitrogen levels ranging from 148 to 180. Our blood urea nitrogen was never higher than 48 mg. per cent. From this it is seemingly apparent that the amount of urea excreted does not depend on the blood urea nitrogen concentration but on the amount and type of perfusing fluid used. It is also of interest to note that though the urea nitrogen was concentrated in the lavage fluid in reference to the corresponding blood urea nitrogen, the concentration of the lavage creatinine was always lower than the corresponding blood creatinine (see Table). The investigation of these phenomena should warrant further study. The difficulty of removal of creatinine shows that this waste product value reflects a more reliable picture of the uremic stage and of its important prognostic value.

We attribute our not having difficulty with our tubing clotting and channelization to the fact that we used moderate Wangensteen suction on the outflow tubing. Even though we could culture streptococci and staphylococci from our lavage fluid, clinical peritonitis did not develop. The fact that our lavage period lasted six days with no peritonitis was probably due to our strict aseptic technique and the proper use of antibiotics.

This case shows the feasibility and efficacy

of removing the "uremic substance" from the circulatory system during the period of renal tubular failure with no difficulty, and maintaining the patient until tubule regeneration has set in. The main criterion for the institution of this procedure is the reversability of the tubular damage. This reversability is found outside of mercury bichloride poisoning in cases of toxicity due to sulfa drugs, carbon tetrachloride, lysol, phenol, and in cases of incompatible blood transfusions and crush syndrome.

Previous authors had difficulty with Thyrode's and modified Thyrode's solutions, in as much as generalized edema invariably developed. In our case we used Hartman's and 5 per cent glucose plus normal saline solution for our lavage fluid with no over-hydration. It is of importance to have the values of the lavage fluid electrolytes correspond to the body fluid electrolyte values. There can be no set regime of perfusing fluids used.

Complete diuresis set in on the eleventh day after the ingestion of the poison with specific tubular concentration function reaching its highest level on the fourteenth day after ingestion at which time the renal excretion of urea nitrogen was 54.98 gm. per twenty-four hours indicating complete tubular regeneration in reference to excretion of "uremic substances." These findings correspond to the statistical findings of Sollmann and of Lomholt.

SUMMARY

1. Effective treatment of uremia caused by ingestion of four grams of mercury bichloride by peritoneal lavage.
2. Demonstration of an effective method of removal of "uremic substances" by peritoneal lavage.
3. Simplification of technique making it possible for use in smaller general hospitals.
4. Interesting data warranting further investigation on the blood urea nitrogen and blood creatinine concentrations in reference to the corresponding lavage fluid values.

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Neurophysiological Disturbances Following Electric Shock Therapy (Electroencephalographic Observations)

ANDRE A. WEIL, M.D.

ELECTRIC shock therapy has gained greatly in popularity ever since Bini and Cerletti introduced this method in 1938. Its clinical usefulness has been proven by many investigators in combating depressive emotional reactions,¹ schizophrenias, and even severe psychoneuroses. Neuropathological studies have usually shown few, if any, structural changes in the central nervous system of animals after experimental electroshock treatment.

Yet, neurophysiological investigations for possible cerebral damage have been undertaken only rarely. Considering the world-wide popularity of electroshock treatment, and its general psychiatric application at the present time, possible neurophysiological disturbances after electrocoma treatment have been mostly overlooked.

Numerous investigators have used the electroencephalogram for investigating a variety of neuropsychiatric disorders, such as epilepsy, intracranial tumors, cortical scars, subdural hematomas and primary behavior disorders in children. Only very few have investigated the electroencephalographic after-effects of electric shock therapy; yet all investigators have agreed that electroencephalographic tracings after electroshock treatment show a definite resemblance to epileptiform wave patterns.

Most of these papers were in the realm of poor research and left three fundamental questions open to the imagination of the reader. 1. How long do these brain-wave abnormalities persist in the brain after shock treatment? 2. How severe are these changes? 3. What do these changes mean to the clinician?

The results of our two-year research project² concerning these problems have been rather thought provoking; not only to the psychiatrist, but especially to the general practitioner, on whose shoulders frequently rests the responsibility of requesting electroshock therapy.

This paper summarizes the more important electroencephalogram findings on a group of 150 patients who were treated with three to 20 electroshock treatments for a variety of psychiatric disorders. Only 51 patients could be studied electroencephalographically at regular intervals. Brain waves were recorded under standard conditions prior to treatment, four days after the last treatment and, again, fourteen days thereafter. Included in this study are a series of five patients who had a brain wave study six months

The Author

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after termination of a course of electrocoma treatment. Two out of the latter group had over 100 (!) shock treatments (for which we were not responsible).

We noticed, in general, an increase of abnormalities in the electroencephalogram record after treatment, characterized by an increase in voltage output, a decrease in wave frequency and the appearance of various other abnormalities. The increase of abnormalities was usually directly proportional to the number of treatments.

The electroencephalogram of patients receiving less than ten shock treatments had returned to normal in 41 per cent 14 days after the last shock treatment. Of the group receiving more than ten shock treatments, only 14 per cent had returned to normal. Of the two patients with more than 100 treatments, studied after six months, one still retained an abnormal electroencephalogram; one record appeared "normal," but epileptoid patterns made their appearance a few days after sedative medication (barbiturates) was discontinued. This medication had apparently masked abnormal activities.

It appears, therefore, that more than ten treatments increases the electrophysiological disturbances of the brain.

Many of the abnormal wave patterns observed resembled distinctly epileptic patterns, with the exception of one technical detail, hyperventilation, which need not concern us at this time. An electric shock treatment is, of course, from a clinical point of view, an epileptic fit, grand mal type. It stands to reason that epileptoid electroencephalogram patterns observed 14 days and even six months after the last electroshock treatment could only have been produced by the shock treatments, especially when the pre-shock electroencephalogram record was ab-

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solutely free from any such epileptic qualities. True, none of these patients suffered from epileptic convulsions after shock treatment, but rare cases have been described in the United States and especially in French literature,⁴ where seizures occurred in shock-treated patients later on. Kalinowsky, as well as others, has described organic confused psychosis after electroshock therapy, which resembled epileptic twilight states, although they were never called as such.⁵

It should not be said that an "epileptoid" electroencephalogram record means epilepsy in a clinical sense. It may not even mean epilepsy in an electro-physiological sense. But, it means a paroxysmal dysrhythmia; a burst-like deviation from the normal electrical activity of the brain, and it is rarely observed in the well functioning, well integrated human brain. It indicates, universally, some form of pathology of neuronal integration, and it indicates damage, even though the damage may not be demonstrable structurally with the methods available to us in 1947.

The fact that more than ten treatments definitely produces increasing electroencephalogram abnormalities should caution us to revert to psychotherapy as early as possible. Of course, this cannot always be done, especially in schizophrenic reactions.

It should also be mentioned that the age group between 15 and 29 years and the group between 45 and 62 years showed a much higher percentage of grossly pathologic electroencephalograms after shock treatment, than did the middle-aged group. We feel, therefore, that especially in young people, electric shock therapy should only be used after a careful selection of patients.

Electroencephalogram changes seemed less pronounced after electroshock therapy² when unidirectional current was used (Reiter apparatus),⁶ than when alternating current was used. This observation, previously reported by Proctor and Goodwin,⁷ has never received its due attention. As long as we can avoid it, we should not ask for more confusion, memory changes, and electroencephalogram abnormalities than we usually get due to shock treatments. Unidirectional current minimizes all three points.

We found some clinical relation between various changes in the brain waves and the psychiatric picture: (a) An abnormal pre-shock record usually indicated that a longer course of treatment was necessary to achieve clinical improvement. (b) A normal pre-shock record promised a better clinical result from electric shock therapy than an abnormal one.

It is, therefore, advisable to give every patient a brain-wave test before electroshock therapy is administered. If nothing else, at least we can get a possible prognostic cue.

It cannot be foretold at the present time, how

long brain-wave abnormalities persist after electro-coma treatment. We only know that these abnormalities persist much longer than any clinical neuropsychiatric study of the patient would reveal. It is entirely feasible that these changes are transitory and that they do not necessarily mean permanent brain damage, nor even functional damage. It also should be borne in mind that the individual cerebral tissue does not react exactly alike to the electric current in any two patients. The same number of electroshock treatments may be followed in patient A by profound brain wave changes, whereas patient B may show only minimal or no pathology in his brain wave record.

SUMMARY

Electroencephalographic tracings after electroshock treatment reveal the appearance of epileptiform wave patterns. The practical application of this problem is discussed, summarizing the electroencephalographic findings in a large group of patients who submitted themselves to a course of electroshock therapy. It appears that unidirectional, fluctuating current produces less abnormal brain wave formations than the commonly used alternating current. More than ten shock treatments—although sometimes clinically necessary—produces generally longer lasting and more pronounced brain wave abnormalities. The youngest and the oldest age groups show the most pronounced electroencephalographic abnormalities after shock treatment. It appears also, that a normal pre-shock electroencephalogram promises a better clinical result from electroshock therapy than an abnormal one.

It is, therefore, suggested that whenever clinically possible—

- a) Electroencephalographic studies should precede electroshock therapy.
- b) Psychotherapy should be substituted for electroshock treatment at least after ten treatments.
- c) Electroshock therapy should be used in older patients and very young individuals only after the most careful selection of patients.

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Increasing the Efficiency of Public Health Administration and Expansion of Services Imperative

E. R. SHAFFER, M. D.

"PUBLIC Health undoubtedly faces one of the greatest challenges today since its evolution as a science."

This statement was made a few years ago when the country was involved in the great war. The slogan which was used then: "Prepare for expanded service in a national emergency," was just as true a philosophy in the field of public health administration as it was for other phases of our economy. The same philosophy applies today when it is equally as important that we set our course and steer the ship of public health in the proper direction in the interests of world rehabilitation and to meet the challenges of an impending new world crisis.

An outlook which seemed bright a short time ago, with opportunities for fulfilling long sought public health aims and needs, has been darkened and the rays of optimism have been shadowed by the new clouds and storms of conquest for material possessions of the world. These dark clouds in the horizon are new and definite threats to our many years of planning and accomplishments in public health administration. Our inalienable rights to life, liberty and the pursuit of happiness, have been challenged again. Our future standards of public health depend upon the strength of our defenses we build now.

No nation can continue to exist, possess and sustain its strength, if its people are to become physically unfit. We must recognize the importance of supporting our country with our every action and our every ounce of strength as it takes the leadership in world affairs and prepares again to defend itself if necessary. It still behooves us who are in the field of public health and education, to fight more diligently against the common enemies of mankind: Ignorance, disease, malnutrition, physical impairment resulting from vocational and avocational re-alignment, and from maladjustment, environmental sanitation problems and unnatural influences, forced upon us as a result of the international situation.

FIRST DEFENSE, PREVENTION

We must also be mindful of the importance of holding the health gains already made and to strengthen these gains by further entrenchment and development of our public health resources. We furthermore must assume a public responsibility of prophylaxis against disease and its complications. Our first line of defense must be: prevention.

One of the major steps in this desired achievement may well be by increasing the efficiency

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of public health administration, particularly in Ohio, by elimination of duplication of departmental jurisdictions, and increasing standards of performance with appropriate mandatory statutory provisions.

OLD WEAPONS—MODERN ENEMIES

In the author's opinion, this can best be accomplished in Ohio by looking backwards over our 28 years experience of public health administration under the existing statutes and evaluating the advantages and the weaknesses of the present organization and administrative policies as fixed by statutes enacted more than a quarter of a century ago.

The biological enemies of mankind are ever on the offensive, may we say, modernizing their attack against their adversaries. May we not expect as much from the army of defense, the public health agencies? Are we in public health service going to accept the challenge thrust upon us and proclaim that "they shall not pass?" We must and we shall accept that challenge by first rebuilding our lines of defense by modernizing our statutory authority and reorganization of our health districts.

If this is true—and I believe it is true—then we should take the necessary steps now to correct these weaknesses and improve the desirable features of our present public health sections of the Ohio General Code to meet these modern needs and responsibilities to better permit increased efficiency of local and state public health administration. This task should not be too difficult. Our people are now more public health minded and "physical fitness" conscious and we have a right to expect the fullest co-operation from all who are unselfishly sincere in the interests of public health service. We must

meet this challenge to public health or ever after be forced to admit we failed in our obligation.

FORTITUDE IN ORDER

Such effort calls for intellectual and moral courage. It is no longer a question whether or not we in Ohio are in need of redrafting public health legislation, but how prompt and bold we should be to accomplish it.

Such is the purpose of proposed amendments to pertinent sections of the public health statutes of Ohio which will be discussed in this article. The author did have an ancient and modest dream in the year 1913, which at that time embodied many of the principles involved in the proposed amendments. This ancient proposal suffered from a "miscarriage" and the "baby" was not born, possibly because of the inexperience of the "obstetrician." Others saw the light that dawned on the horizon of public health service in the interests of efficiency and a great step forward was made in Ohio in 1919-1920 by the enactment of the "Hughes-Griswold Law" which has now served its maximum usefulness, after a quarter of a century application.

The proposals which should be introduced early in the forthcoming session of the General Assembly of Ohio, should be a bill to amend certain sections of the General Code and to supplement other sections relative to the creation of general and special health districts.

Such a bill was prepared and presented before the Ohio Federation of Public Health officials on September 24, 1942, and also presented before the Ohio Parent-Teachers' Congress on October 15, 1942, to the Ohio Department of Health, as well as The Council of the Ohio State Medical Association, none of whom took serious cognizance thereof. Since that time, organized medicine has put forth admirable efforts and assistance to local and state health programs, but under unfavorable statutory provisions, obsolete and enacted a quarter century past.

COUNTY AS UNIT

In brief, these proposed amendments provide for the county as the unit of organization, which unit will include all townships, villages, and cities situated therein. Under such a plan of organization, the whole county unit, in most instances, will provide larger resources to finance and justify an equitable and more efficient program, very necessary in the face of our national emergency, and the postwar era. It will, furthermore, eliminate the over-lapping of jurisdiction of health departments in the same county; contribute to economy and improved service and general health education. The proposals, furthermore, attempt to correct the many errors and weaknesses in our present statutes and clarify the language thereof, as

observed during the past quarter century of voluntary city and general health district organization.

Relative to the county as a unit of organization, the proposal provides that in the event cities of 100,000 population or more do not choose to unite with the county unit plan, they may organize as a special health district. This provision affords an opportunity for such municipalities having an efficient department of health and financially able to provide such service, to continue as a separate health district. In my opinion, this, being an optional feature, meets the constitutional prohibition pertaining to classification of cities other than is provided by the state Constitution.

YARDSTICK AT STATE LEVEL

In the opinion of many experienced public health executives, it is time that Ohio takes a stand and again assumes the leadership among the states of the nation in the establishment of a comprehensive and consistent legislative plan in the field of organized public health, by meeting our problems boldly and providing a "yardstick" for the solution of these problems courageously.

It is believed that 80 per cent of our small city health districts and 40 per cent of our general health districts have not improved their quality nor quantity of public health service under the voluntary or optional plan in the interests of their child and adult population during the past twenty years.

Ohio has 88 counties with the power to form general health districts. There are, by the 1940 census, 114 cities over 5,000 population with the power to form city health districts. By virtue of cooperative agreements and combinations permitted under the law, there are 80 general health districts in the state which serve the 88 counties and 35 cities situated therein. These 80 districts are supervised by medical health commissioners as required by law although 32 of the 80 are only on part-time basis. There are 80 separate city health districts served by both medical and lay health commissioners, 58 of whom are part-time.

There are 55 cities in the state with a population between 5,000 and 10,000 and 51 cities with a population between 10,000 and 100,000. Ohio has 8 cities of 100,000 population or more, according to the 1940 Federal census, which could be organized as special health districts in accordance with the provisions of the proposed amendments. It is true that many of the smaller cities have contracted with or voluntarily formed a part of the county unit as now provided by the existing statutes. These cities thus enjoy the fruits of full-time public health service and future program planning. Many others are not finan-

cially able, under the present form of raising funds, for adequate public health service and cannot improve their programs even if they were inclined to do so.

Many counties in Ohio have several separate health departments serving separate health districts situated within the county whose duties and services overlap and with different policies, which contribute to confusion of both the departmental personnel and the general public. Such policy of public administration tends to increase the cost of administration and is not conducive to efficiency nor standardization of accepted public health practices. All of this works to the detriment of the safety and welfare of the community and state.

The amendments further provide for a direct tax plan for public health administration. As long as the public health profession must pay homage to city councils, budget commissions or other appropriating bodies of all political subdivisions with various political complexions, health departments will never be adequately financed nor staffed. We in Ohio have experienced during the past quarter century this difficulty of financing our programs, no matter what the degree of efficiency of the department. Political sub-divisions always seem to find ample monies for the construction of roads, bridges, buildings, automobiles (heretofore) for the officials and elective officers, but have shied at adequate appropriations for the public health service. It is true, however, that during recent years some appropriating bodies have been more generous in their cooperation with the public health agencies.

We, therefore, are proposing that a direct tax be authorized and collected for public health purposes, in the amount of a minimum expenditure of 75 cents per capita. Most authorities in the public health field urge a minimum expenditure of \$1.00 per capita; others claim there should be a minimum expenditure of \$2.00 per person. This proposed minimum of 75 cents, along with the other provisions of the proposed amendments, will increase the efficiency many fold.

VOLUNTARY COOPERATION

In this connection, we in Summit County have succeeded in obtaining the voluntary cooperation of the majority of our rural school districts, by way of assisting in paying for medical, dental, and public health nursing service in the schools of our district. This plan has been in operation for the past eight years and agreed to for the current school year on an approximate basis of 70 cents per pupil. This program has provided a school dentist, two part-time school physicians, public health nursing service for the schools, and a fully equipped mobile dental unit.

In addition, a planned educational program is in effect concerning social hygiene education under the subject of "Preparation for Family Living" in seven school lectures to boys and girls of the eleventh and twelfth grades.

It is conceded that most full-time departments of health devote 40 per cent of their effort and budget to the school system of their district. Therefore, we believe the schools should bear a portion of the cost of maintaining this important service. We believe further that this plan should be made mandatory for all the county health units. These proposed amendments, therefore, provide for the additional direct tax by all school districts of a minimum of 70 cents per pupil enrolled and to be paid to the "district health fund." This proposal, however, excludes boards of education of proposed special health districts. However, if it is desired to insert the phrase, "and special health districts," I am sure it would meet with the approval of the author of these proposed amendments.

The proposed amendments, furthermore, provide for a state equalization fund for weak health districts. It is intended to replace the existing statutes providing for "subsidy to all health districts."

It is common knowledge that this reimbursement to city and general health districts, on a basis of the expenditure made by local health districts for "a health commissioner, a public health nurse, and clerk, if any," has consistently been one of the biggest headaches of the state and local health administration since its enactment. In fact, the form now in effect was not the true form suggested and designed by the original drafters of the "Hughes-Griswold Act," but a substitute injected by the legislators as an inducement to local health organization.

SUBSIDY LIMITATIONS

The present subsidy section 1261-39 General Code of Ohio, has two major objections. As subsequently interpreted by the Attorney General, the maximum subsidy of \$2,000 per annum permitted by the section need not be met by succeeding General Assemblies and has not been. For example, the amount available by appropriation for 1948 will permit a maximum subsidy of \$1,720 at best to any health district. In fact, it may be estimated that since this law was established, the state appropriations have been short of this very low ceiling in an amount exceeding \$8,000,000.

The second difficulty in the present law is that the state subsidy is contingent only upon the expenditure of local money in the ratio of two local dollars to one state dollar—up to the limits of the maximum, less the shortage of the appropriation. There are no standards relative to qualified personnel or sound program.

We may justly ask the question: What induce-

ment or how helpful is a reimbursement of a maximum of \$2,000 per year to most of the cities and many of the counties whose budgets are not affected materially by the presence or absence of this nominal sum? Whereas, twice or three times this amount, made available to many of our weak counties having a low tax duplicate and small population, would work wonders in the control of communicable disease, improve sanitation, medical and dental supervision of school children and general health education. Such material financial aid to those weak health districts would affect the presence or absence of public health problems of adjoining or other districts of the state.

CIVIL SERVICE REQUIREMENT

Moreover, the proposed amendments include the requirements of civil service for general health districts and establishing the qualifications of the health commissioner and the appointment thereof.

Undoubtedly there will be some communities and part-time health commissioners who will oppose this feature of the proposed amendments. As a token of sincerity in the case of the author, I desire to go on record that in event these proposed amendments are enacted into law, and in event someone is believed to be better qualified to administer the provisions thereof in his local health district than he, he will gladly and willingly step aside for a better qualified person. That is what is meant by "unselfishly interested" in public health service.

The proposed amendments further provide that each general and special health district, on or before one year after the date that the new law becomes effective, shall adopt and put into full force and effect, uniform food, restaurant, and milk regulations as may be recommended by the state food and milk commission. The proposed amendments further provide an authorization section creating such state food and milk commission and designates specific individuals and representatives from specific organizations to be members of the commission, the chairman of which shall be the state director of health. It is provided that this commission shall meet and organize within 30 days after the law becomes effective and the commission shall complete its work and make such recommendations to the district boards of health within a period of nine months following the effective date of the act.

This problem of supervision of milk and food sanitation has been a difficult one for a long period of time. Various attempts have been made and considerable effort put forth to solve the problem in a way that would be in the interests of the food and milk industry and milk producers and the consumers of these products. Consider-

able confusion has constantly arisen due to the absence of uniformity of application in different counties and by separate departments of health situated within the same county.

UNIFORMITY NEEDED

Inasmuch as the food and milk supply to large urban areas involves a large milk shed, the absence of uniform milk regulations, particularly, has resulted in real difficulties and has not been conducive to the interests of the industry itself and particularly to the health and welfare of the consumer.

The statutes concerning hotel and restaurant sanitation should be amended to the degree of transferring state supervision in this respect from the State Fire Marshal's Department to the Ohio Department of Health. The present statutes are obsolete and provide multiple restaurant and hotel sanitation by departments not qualified to render modern sanitation technique to eating and drinking establishments.

The author in cooperation with other local departments of health did put forth considerable effort during 1945-1946 General Assembly in an attempt to correct this evil, but without success.

State and local district departments of health should be held solely responsible for sanitation standards, rather than duplication of and difference in standards as now prevails.

CENTRAL SUPERVISION

My experience convinces me that to do this job right we must have a central supervision unit in the Ohio Department of Health, establishing the minimum standards and legislation requiring local health districts to comply with these minimum standards under qualified personnel.

Public health administration must be entirely independent from political changes or influences. It must never be used as a dumping ground of "lame ducks" or incompetents who may feel the public health administration field is an easy berth. There is no public service that demands greater sincerity and qualifications.

These public health agencies must be staffed by career men and women, specialists of proved courage and demonstrated ability in their respective field.

Financial support must be obtained in order to train and interest men and women of special adaptability to public health education and service.

Give us all these, then Ohio may again take its proper place among states of our nation in efficient and effective public health service, otherwise socialization, Federalization or some other undersirable "ism" may take from us the privilege of self-service and independence now enjoyed.

Principles of Early Management of Hand Injuries

Following injury, the hand is particularly susceptible to the development of complications leading to serious disabilities. For this reason, it is important that the freshly injured hand be given the most careful protection against such complications as result from added infection, additional tissue damage and stiffening.

The principles governing the provision of this protection may be briefly stated as follows:

I—Protection against added infection: Any open accidental wound of the hand may be assumed to be contaminated. It is important that no additional infection be added. This requires:

a. Protection of the wound at once with a sterile dressing.

b. Avoidance of putting anything into the wound, such as instruments, gauze, applicators, sponges, or any sort of antiseptic.

c. If any cleansing of the areas around the covered wound is done, it should be with soap and water only.

d. Avoidance of all efforts at treatment of the wound by exploration, debridement or repair of damaged structures until adequate facilities are available. Adequate facilities for this purpose should include a location where surgically aseptic technic is employed, adequate anesthesia, proper instruments, sufficient assistance, good lighting, and the provisions of a bloodless operative field.

e. Application of a sterile dressing which will protect against the entrance of foreign material. Such a dressing should be voluminous, firmly applied with moderate pressure, separating the fingers from each other, and should maintain the hand and fingers in the position of function.

f. Antibiotic drugs should be administered systemically, not locally, in full dosage. Tetanus antitoxin (or toxoid) should be administered when the conditions warrant.

II—Protection against added tissue damage and deformity: Immobilization of the hand is required in any major injury, whether the wound involves skin, tendons, nerves, joints, or bones. Immobilization should be governed by the following principles:

a. Immobilization should be employed as soon as possible after receipt of the injury for protection from further tissue damage.

b. Following definitive treatment of the injury, the immobilization should be continued as long as may be required for healing to occur.

c. Immobilization should be in the position of function (position of grasp) in order to maintain optimum relation of bone fragments and of soft tissue structures.

d. The position of function in immobilization is necessary to prevent disabling deformities,

contractures, muscle weakness and joint stiffening, and to insure the earliest return of usefulness after healing.

e. Flat splinting of the hand or any of its digits must be avoided at all times.

This paper presents the principles elicited by the American Society for Surgery of the Hand.
—Robert M. Zollinger, M.D.

KEEPING UP WITH MEDICINE

• RECENT advances in biochemistry has highlighted the importance of minerals in growth and development of the human organism.

* * *

• A PROMINENT northwest surgeon now recommends that no hysterectomy be performed until there has been consultation with another competent surgeon. He cites the 1946 experience of a large city hospital where 24 per cent of 187 hysterectomies were, upon review, considered as contra-indicated.

* * *

• FOR the routine treatment of infections of the urinary tract, mandelic acid and the sulfonamide compounds are still the drugs of choice.

* * *

• THE use of tetra-ethyl-ammonium chloride has been advised as the best means of the post-operative results in the surgical treatment of hypertension.

* * *

• HIPPOCRATES said that of all the professions Medicine is the most distinguished since it aims not only to heal the body but also to calm the mind and spirit.

* * *

• BE willing to take time to listen to a patient until he feels that he has a friend who is trying to understand his case and to help him.

* * *

• CHRONIC Brucellosis should always be considered in the differential diagnosis of any chronic, low-grade, remittent, or recurring illness with tiredness and exhaustion as a feature.

* * *

• BEARING in mind the physiological effects of the tocopherols (vitamin E), they may prove of value in cases of osteomyelitis, and delayed wound healing.

* * *

• ANAL cystitis and perianal dermatitis, the latter frequently of fungus origin, are the two commonest causes of pruritus ani.

* * *

• HENRY CHRISTIAN recently called attention to the fact that in these days of specialization the medical student is the only one now supposed to know medicine as a whole.—J. F.

Cystic Fibrosis of the Pancreas

WILLIAM SINCLAIR, JR., M. D.

A white male, S.R., aged 9 weeks, was first admitted to Babies and Childrens Hospital on March 17, 1947, with a three weeks' history of severe cough, coryza, and vomiting. Three days before admission the infant developed slight fever.

The patient was born at term following a normal pregnancy. The parents and other sibling are living and well. Birth weight was 2955 grams. During the first two weeks of life the infant often vomited and had watery yellow and green bowel movements six to seven times daily. This gradually subsided following change from breast feeding to formula. He gained weight slowly reaching a maximum of 3500 grams.

On admission the patient was acutely ill. The temperature was 37.7 degrees, pulse rate 120, respiratory rate 48. Body measurements included head 36.5 cm., chest 33 cm., abdomen 32 cm., length 56 cm., weight 3375 grams. Skin turgor was normal and there was moderate subcutaneous fat. The right ear drum was inflamed. The pharynx was red. There was moderate intercostal and subcostal retraction on respiration. The lungs were normal to percussion. Coarse rales were present throughout all lobes. The heart was normal except for tachycardia. The liver was palpable one finger-breadth below the right costal margin. Otherwise the physical examination was not remarkable.

Pertinent laboratory observations include the following: Several urinalyses were normal; red blood count 3.36 million; hemoglobin 6.25 grams; white blood count 13,950 with 32 per cent segmented neutrophils, 14 per cent unsegmented neutrophils, 52 per cent lymphocytes, and 2 per cent monocytes. Kline test was negative. Blood serum proteins were 6.3 grams per 100 cc., globulin 2.8 grams per 100 cc., albumin 3.5 grams per 100 cc., A/G ratio 1.3. Nose culture yielded hemolytic staphylococcus, *N. catarrhalis* and *Pneumococci*, throat culture: Beta hemolytic streptococci, *N. catarrhalis*, *Pneumococci* and later hemolytic *Staphylococcus aureus*.

Chest X-ray revealed a dense streaking along the course of the descending broncho-vascular markings bilaterally and accentuation of these markings elsewhere, consistent with bronchopneumonia. On April 15, 1947, the duodenal juice showed normal proteolytic (trypsin), amylolytic and lipolytic enzyme activity. On April 19, 1947, the total fat in the stool was 0.26 grams per gram of stool, or 1.25 grams of fat in twenty-four hours (modified Fowweather method).

The hospital course was marked by frequent episodes of fever, accentuation of cough, and marked respiratory distress. There was gradual weight loss and retardation in development. Terminally the infant was emaciated, lethargic, and developed a protuberant abdomen. The stools were generally large, soft, yellow, and on occasion foul. The total fat content of the

stools remained the same. The infant was too ill for further duodenal-juice studies. Chest X-rays at intervals showed no significant change. Nose and throat cultures continued to yield *Staphylococcus*. Treatment included penicillin intramuscularly and by aerosol nebulization, sulfadiazine, one whole blood transfusion, low fat high protein diet, vitamins, and steam inhalations. Pancreatin was given for one week. Death occurred June 5, 1947, at the age of 5 months.

AUTOPSY

Autopsy (9666) revealed acute and chronic suppurative and ulcerative bronchitis and peribronchitis, bronchopneumonia, cystic fibrosis of the pancreas, and a congenitally bicuspid aortic valve. Bronchiectasis was absent as was epithelial metaplasia and cystic disease of the other organs. Friedländer's bacillus was cultured from the thick, bronchial secretions and from the lung. The pancreas was grossly normal, weighed 5 grams and measured 5.5 x 1.5 x 0.7 cm.

Microscopically the head, body and tail of the pancreas showed widespread focal replacement of parenchyma with dilated ducts and acini which formed cysts of varying size. Many of these cysts contained homogeneous and concentrically laminated eosinophilic material which in some instances contained small particles. The cysts were lined by a single layer of low cuboidal or flattened epithelial cells. The changes were far more pronounced in the tail than in the head of the organ. In and about these regions there was moderate increase in interstitial connective tissue which was sparsely infiltrated with lymphocytes and plasma cells. In many places the lumens of the acini were only slightly dilated and contained small amounts of homogeneous nonlaminated eosinophilic material. The acinic cells in these loci contained granules and appeared normal. It is estimated that approximately one-half of the pancreas was involved. The islets of Langerhans were normal. There was no evidence of inspissated secretions in other glandular organs.

DISCUSSION

This case is significant because it calls attention to the fact that the clinical and pathological aspects of cystic fibrosis of the pancreas may be present even though the enzyme activity of the duodenal juice and the total fat content of the stools are normal. This unusual circumstance is explained in this instance by the microscopical observation that approximately one-half of the pancreas is the seat of cystic fibrosis while the remainder is approximately normal.

Andersen¹ has stated that the diagnosis of pancreatic deficiency may be considered disproved if appreciable quantities of enzymes are demonstrated in the duodenal juice. Total fecal fat in normal infants age 2 to 6 months has been shown to range from 0.29-1.30 grams per day with a mean of 0.80 ± 0.31 grams per day. She

Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals of Cleveland as the 39th of a series of cases to be published under the heading, "Case Records Presenting Clinical Problems."

said that patients with pancreatic deficiency invariably have a great increase in total fecal fat excretion.²

The pathogenesis of cystic fibrosis is not completely known. Recent studies of the hereditary aspects of the disease has indicated that the incidence among siblings approximates the 25 per cent expected of a Mendelian recessive trait and furthermore that in several families the disease has appeared in a majority of offspring.³ Stenosis or atresia of the pancreatic ducts has rarely been demonstrated.⁴ Norris and Tyson⁵ have compared the pathogenesis of polycystic disease of the pancreas, liver, and kidney and noted similarities. They express the belief that in polycystic disease epithelial tubules and ducts are first normally formed but become distorted and segmented and fail to undergo normal complete resorption. These segments may then persist to form isolated cysts. Virus infection has been considered to be a factor because of the almost constant upper respiratory infection associated with the disease, but as yet no satisfactory evidence has been presented to establish this concept. Vitamin A deficiency was formerly held to be an etiologic factor but is best considered a complication resulting from the general faulty absorption of fat soluble vitamins.

The studies of Blackfan and Wolbach⁶ have indicated that the pancreatic lesions may be due to an abnormal secretion of the pancreas which becomes inspissated and leads to the distension and atrophy of ducts and acini and the subsequent production of fibrous tissue. Farber⁷ has shown that similar altered secretions may be found in the mucous glands of the trachea, bronchi, esophagus, duodenum, liver, gallbladder, salivary glands, and accessory pancreatic tissue. The cause of the abnormal secretions, however, has not been determined. Baggenstoss, Power, and Grindlay⁸ in a recent preliminary report have postulated that the abnormal secretions of the pancreas may be due to a congenital deficiency of secretin. This concept has not been proven and furthermore fails to account for the altered secretions frequently occurring in other organs such as the salivary glands and trachea. Determination of secretin was not done in this case.

The prognosis has been generally hopeless. The basic problem in treatment is to overcome the respiratory tract infections and the value of penicillin in this regard has not been established, although in some instances meticulous attention to diet, administration of sulfonamides, and adequate penicillin therapy including penicillin aerosol have been successful. The sulfonamides are of limited value and are mainly used for prophylaxis and for treatment of intercurrent infections.⁹ It is conceivable that if the chronic bronchitis, peribronchitis, and bronchopneumonia

had responded to treatment, this patient might have survived as there is evidence that the pancreatic enzymes were produced in normal amounts and that the pancreas at the time of death was composed of approximately 50 per cent normal tissue. Andersen's statement¹⁰ that the cause of death in all cases surviving the first week of life was bronchitis, bronchiectasis, or bronchopneumonia is indeed significant.

SUMMARY

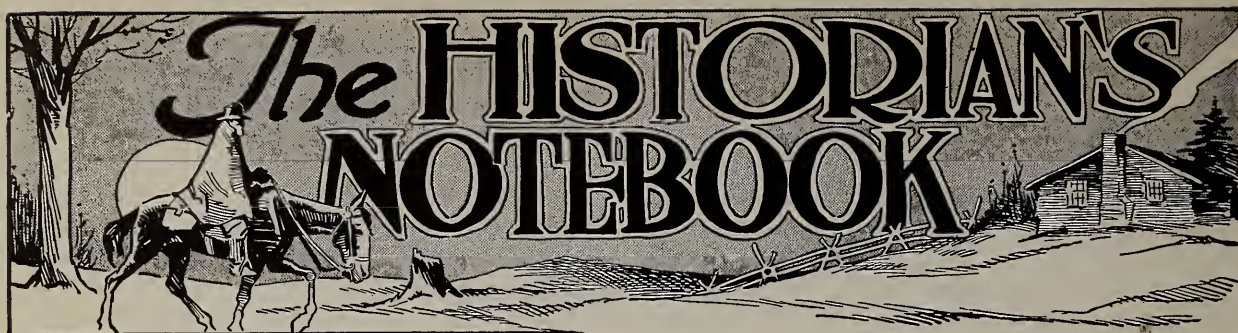
A case of cystic fibrosis of the pancreas occurring in a 5 months old white male infant in whom the pancreatic enzyme and total stool fat studies were normal is recorded. This unusual circumstance is explained by the fact that approximately one-half of the pancreas was involved by the cystic fibrosis, while the remainder was approximately normal.

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Maturity

The nation needs children who have the ability to withstand the pressures of life. An intelligent understanding of the influence of environmental factors and of emotional adjustment is a necessary reinforcement to the best programs of nutritional care and physical hygiene. Pediatricians can make practical application of this fact in contacts with the youngster, as well as by constructive advice to parents. Interpretation and counsel to provide guidance in home training require the application of tact, intelligence and good judgment. Parents must work out many of these problems for themselves. But the ultimate development of emotional stability and good adjustment to the demands of later life require proper environment and the formation of correct habits during early life.—W. W. Quillian, M. D., Coral Gables, Fla., Jr. of S. C. Med. Assn., Vol. XLIV, No. 8, Aug., 1948.



Rufus W. Stearns — Pioneer Doctor of Ohio: His Community Activities

DON M. STEARNS

(Concluded from September Issue)

DR. RUFUS W. STEARNS was not only a very kind and providing father, and an excellent physician and surgeon, but he also took a very active part in the affairs of his community. His education and ability plus the respect that he commanded qualified him for the many positions he held. In those times the doctor, being often the most educated man of the community, assumed much of the responsibility for the advancement of the community.

In 1834, two years after Dr. Stearns entered St. Marys, Ohio, as her first resident physician and surgeon, he and three other men founded the town of Celina. They were aware of certain legal qualifications, and entered into a contract that was indicative of their common sense.

This article of agreement, made and entered into by and between the undersigned as parceners in common, witnesseth: That for the purpose of mutual benefit we have each of us paid in the sum of one hundred dollars to be laid out in the purchase of lands at the centre of Mercer County, for the purpose of laying out a town, to be called by the name of Celina, and for the purpose of convenience in making sales of said town property, making deeds, etc., we hereby employ one of our number, to-wit, Rufus Wilson Stearns, to make if possible, the entries of the land in his own name to make sales, keep the books of the company, make all deeds, etc., etc., during the continuance of this article, and to make all necessary and proper arrangements for furthering the interests of the company in this matter. It is moreover agreed between the contracting parties that, as such tenants in common, each shall bear an equal proportion in expense and share equal profit in dividends, and that when so much money shall be made as to pay the expense of purchase, each shall be entitled to take out his purchase money; and all moneys arising afterwards may either be taken out

or laid out in other speculations for the company's benefit, as may to the county seem proper; and that this contract shall be as good in law, and to all purposes and intents as binding and valid, as if these presents had been in more ample and better form.

Peter Aughenbaugh (seal)

R. W. Stearns (seal)

J. W. Riley (seal)

Robert Linzee (seal)

St. Marys, Mercer County, Ohio, Aug. 25, 1834.

There was also a supplemental contract which explained the costs of the townsite and put on record that Rufus Stearns was to hold the land in his name for the benefit of all.

The lands bought by virtue of the within contract are . . . in the name of Rufus W. Stearns: and are to be held in common for the benefit of all parties, in the same manner as if entered in each person's name, in equal proportions or in all jointly.

Extra costs, \$69.60, making the whole sum paid \$469.16, and each share actually paid in, \$117.29.

The plan of the proposed town was very impressive, even though it was being laid out in a dense forest. The first step toward establishing real streets and buildings was to fell the huge trees. To facilitate this a chopping bee was planned. All neighboring settlers were invited to come to the townsite on the appointed day, and bring their axes with them. There was only one small clearing and an incomplete building at the townsite, but the settlers soon began to arrive to remove the trees from the entire plot. Accommodations, such as rooms with neighboring settlers or possibly tents, were made for those who were coming the night before. From Piqua two barrels of whiskey, tin pails, six dozen tin cups, and the same number of plates, knives, forks, spoons, etc., had been procured.

A beautiful Indian summer day greeted the

Excerpts from a Thesis for Honors by Don M. Stearns, Lima, Ohio, Otterbein College. Class of 1948, and great-grandson of Dr. R. W. Stearns.

men as they started to work on the forest. In companies of from fifteen to twenty men under a leader, they soon began to clear the trees from the townsite. While they were chopping the women would bring them eggnog, sandwiches, and doughnuts. After the last tree fell with a thunderous crash all jubilantly assembled to partake of the feast that had been prepared by the women. The seventy experienced choppers sat down to a meal of venison, wild turkey, pigs, and chickens. After the feast the musicians that had been obtained from Ft. Recovery took over, and the dance consummated a day of hard and profitable labor. Probably they followed the custom of the day and danced until shoes were worn through, and the sun again shone.

The founders early dedicated a large public square, and gave land to the Methodist Episcopal, Baptist and Presbyterian churches. Three acres at the edge of the city were donated for use as a public burying ground for all denominations. Today, the wide streets of Celina; the good location of her churches and other buildings are monuments to the foresight of the men who founded the town.

On April 15, 1849, the first meeting of the City Council of St. Marys was held at Dr. Stearns' corner, which was then the northeast corner of Spring and Main. Those present were Dr. R. W. Stearns, William Hollingsworth, Joseph Kelsey, and R. B. Gordon, all elected trustees and sworn in with W. L. Ross, the elected recorder, by Judge Simpson. Most of the meetings of the town council were held at Dr. Stearns' corner while he was a member. On May 7 of that year ordinances were enacted to (1) levy a five (5) mill tax on the valuation of the town, (2) control the use of spiritous liquors, and (3) to preserve the peace and order of the citizens of St. Marys. In 1825 the first jail was built in St. Marys, but on New Year's Day 1838, an insane prisoner set it on fire and it burned to the ground. On July 2, 1849, Dr. Stearns and two other men were appointed a committee to rectify this lack of a jail. They were to ascertain the probable cost of building, buying or renting an edifice suitable for a calaboose.

With the exception of the first meeting of the St. Marys' School Board, Dr. Stearns' corner was for many years a meeting place where these board members would plan the education of the children in and around St. Marys. The famous words of the Ordinance of 1787, "Religion, morality, and knowledge, being necessary to good government and the happiness of mankind, schools, and the means of education shall forever be encouraged," show to some extent the unique political structure under which these settlers in a new country were working to give the three R's to the children of the community. Credit must go to the early pioneers who took time to guar-

antee to their children free education by establishing public schools under the legal provisions that controlled this territory. There were numerous private schools before free education was realized. In fact, Dr. Stearns sent a daughter to a Miss Ward for instruction before the St. Marys school system had been organized.

The minutes of the first three years of the school board beginning August 18, 1856, are in the hand of Dr. Stearns, who was appointed recorder pro tem, and then elected recorder.

The rates per week for scholars not in the St. Marys' school district were: primary department, twenty cents; grammar department, thirty-three and one third cents; and higher branches, fifty cents. The school was divided into three terms. The first was to begin September 15 and last fourteen weeks; the second to begin on the first Monday of January and continue for twelve weeks; and the third to start on the first Monday in April and continue at the discretion of the board of directors.

The pay of the teachers ranged from five dollars in the primary department to as high as ten dollars per week in the upper grades. The superintendent, Mr. Fairbanks, was contracted at \$675 per year, and he also served as librarian. Mrs. Margaret Banks was obtained to teach a colored school for \$5.50 a week. She was to furnish her own house and wood. This school was to continue for twelve weeks unless the directors thought it expedient to terminate it before that time had elapsed. There were thirteen colored scholars.

The many duties that Dr. Stearns performed during his tenure on the school board were varied and interesting. He was appointed to effect an insurance upon the school building. The value of the property was put at \$5400, and the insurance covered \$3300. He was one of a committee of three to ascertain the cost of seats for the school, and one of a committee of two appointed to have a well dug. They got 78 seats for \$77. The well cost fifty-five cents a foot making the total cost \$11.82. With William Hollingsworth he was to report on the books that the school should order the next year, and at the same time was appointed to a committee of three to get the propositions from the teachers. He was appointed to obtain the cost of having printed the catalogue of scholars, the report of the Board of Education, and the superintendent's report. For taking enumeration of scholars an extra three dollars was allowed Dr. Stearns. With Herzing he was to ascertain the price of a school bell, and make arrangements to purchase one for the schoolhouse. They purchased a two-hundred pound bell, F sharp, for \$90.

Not all was prosaic business, however, and one interesting incident that pertained to the little colored school, which at that time was a

Celina N. E. Ohio



Description

Lots from No. 1. to No. 156. each 5/pols wide by two long
 Main and Logan streets each 6/pols wide

Lots No. 23 & 119. Conated for Schools

No. 44. Methodist Church

No. 100. Baptist do

No. 149. Presbyterian do

Public Sq. 8 by 21/pols.

Center Street 3/pols wide all others 4/pols, alleys 1/pol

Burial Ground of 3 Acres near the plat for all

R. M. Stearns & Co Proprietors

very small building standing where the church now stands on Perry Street, brought some humor to the school board. It seems a gaunt, tall dapper-looking colored man had asked one of the members of the school board for a position as teacher at the colored school. The member advised him to write an application and present it to the school board. He wrote thus:

Gentlemen:

The undersigned most graciously, respectfully, and felicitously herewith desires to ask your honorable body for the gracious privilege of teaching the colored school in your jurisprudence.

Yours incognito,
Jabey Jenkins,
Perceptor.

Evidently this body of pioneer citizens was not deeply impressed for Jabey did not get the privilege of teaching at the school.

The first year of school was ended officially July 2, 1858. They had employed six teachers who had attempted to teach 421 students the elements of reading, 'riting, and 'rithmetic. The school had been divided into three terms totaling thirty-seven weeks. The colored school had had thirteen scholars. Dr. Stearns was granted fifteen dollars for the use of his rooms, stationery, fuel and lights, and his services as clerk. Although in the midst of a heavy practice and a growing home, Dr. Stearns remained on the school board for several years.

One of the greatest forces for good was the church. Dr. Stearns was a very devout Christian, and a member of the Methodist Episcopal Church for 36 years. He first attended church at St. Marys in a small log building, then in 1838 a frame building was obtained. In April, 1866, when the quarterly conference was held, he was among those of the board of trustees elected to supervise the erection of a new church. Dr. Stearns, G. W. McLaughlin, and E. M. Phelps were made the building committee. The new stone church was completed in 1867. In eulogies to Dr. Stearns there are frequent mentions of the positions he held in the church, and many evaluations of his life as being an example of practiced Christian virtues. Shortly after his death an article appeared in the St. Marys paper which contained this expression toward him: "God bless the faithful veterans of the old church of our childhood, whose memory has done much to keep unshaken the faith of our youth. One face and figure we were wont to see, we missed—a tall form wrapped in a well-worn cloak, a plain earnest speaking face—the face of Dr. Stearns."

On February 25, 1864, the first organization of the Elmview Cemetery Association took place. Several prominent men of the town, Dr. Stearns included, were the original members and trustees of the Elmview Cemetery. At this time each mem-

ber was issued a membership card that allowed the entire family admittance to the cemetery. On the back of the card issued to Dr. Stearns were the numbers 57, 58 and 62. These numbers designated the lots owned by him. Dr. Stearns' mother died in 1875, and was buried in lot 57. Dr. Stearns died January 5, 1877, and occupies number 58, while Sarah Ann, his beloved wife, was placed in lot 62 when she died September 23, 1901.

Dr. Stearns had lived a hard but very profitable life. He labored tirelessly as a physician and surgeon, and attained a reputation for taking the time to advance many organizations necessary for the development of his community. Largely through the efforts and actions of doctors such as Rufus W. Stearns the medical profession has achieved standards that cannot be excelled. The doctor in those pioneer days was one of the most valuable members of the community, for he administered not only to the needs of the body, but to the needs of the soul, and the community as a whole. The standards have not changed, for today the doctor is still one of the most honored and valuable members of the community. He takes time from a busy medical practice to serve his community in a variety of ways forever upholding the noble name, Doctor.

Perhaps the best way to end this account of the life of Dr. Rufus W. Stearns would be to turn to the Bible, where in Ecclesiasticus is found:

Honour a physician with the honour due unto him for the uses which ye may have of him; for the Lord hath created him.

For of the Most High cometh healing, and he shall receive honour of the king.

The skill of the physician shall lift up his head; and in the sight of great men he shall be in admiration.

The Lord hath created medicines out of the earth; and he that is wise will not abhor them.

Was not the water made sweet with wood, that the virtue thereof might be known?

And he hath given men skill, that he might be honoured in his marvelous works.

With such doth he heal men and taketh away their pains. Of such doth the apothecary make a confection; and of his works there is no end; and from him is peace over all the earth.

Noah Webster, Letters on Yellow Fever Addressed to Dr. William Currie, with an introductory essay by Benjamin Spector. (Supplement No. 9 to Bulletin of the History of Medicine, \$2.00. *The Johns Hopkins Press, Baltimore 18, Maryland.*)

Few of us realized that the great lexicographer had a notable place in the annals of medical literature. His writings constitute fundamental building stones upon which, in more recent times, has been erected the modern structure of epidemiology.

Can U.S. Medical Plan Be Stopped? . . .

Yes, Says Hawley in Challenging Address, Providing Medical Profession Will Give More Support to Voluntary Prepayment Programs

AT the time of the June meeting of the American Medical Association, Dr. Paul R. Hawley, chief executive officer of the Blue Cross and Blue Shield Commissions, addressed the Conference of Presidents of State Medical Associations and the House of Delegates of the A.M.A.

In his talks, which have been the subject of much comment—some favorable, some unfavorable—Dr. Hawley declared that the future pattern of the practice of medicine hinges largely on the rapid development of the voluntary prepaid hospital and medical insurance programs to their greatest potentialities.

Few will disagree with Dr. Hawley's warning that a Federalized system of compulsory health insurance will be enacted unless the voluntary plans are expanded and their coverage increased; unless the medical profession as a whole gives more vigorous backing to the voluntary programs and takes a keener interest in proving to the public that they can meet admitted needs and can offer the people services of a high standard.

TWO FORMS OF DICTATION

There are those who will take issue with Dr. Hawley when he intimates that the medical profession must meet the demands of labor unions as to type and scope of coverage and on matters of administrative management. There are those who can see no material difference between dictation by labor leaders and dictation by government bureau directors—politicians.

There are those who will not agree with Dr. Hawley's intimation that medical care plans must be on a service basis rather than on a cash indemnity basis.

There are those who will differ with some phases of the proposal which he suggests to establish a national agency for handling national accounts, although not disagreeing in principle with the idea that some such organization is needed.

NOT SO BAD—MAYBE

There are those who will resent Dr. Hawley's caustic criticism of so-called organized medicine, contending that most of the medical societies of the country have given far more backing to the Blue Shield program than Dr. Hawley's remarks would imply.

There are those who will disagree with Dr. Hawley's belief that it is useless for the medical profession to continue to try to educate the

people about the dangers of Federalized medicine and that active interest in political affairs by physicians will be a futile gesture.

There are those who won't like any of Dr. Hawley's comments, contending that there is no need for a change; that Dr. Hawley has painted the worst possible picture of the future in order to sell something; that Dr. Hawley is presumptuous in trying to tell the medical profession what it must do.

A REAL JOLT

Nevertheless, despite criticisms, justifiable or otherwise, which may be made of his address, Dr. Hawley has given the medical profession something to think about—and seriously.

Those who know something about the present attitude and temper of some high political leaders of all parties, of leaders of organized labor, and of many John Q. Publics will agree with Dr. Hawley that now is certainly no time for complacency. They will sense the need for vigorous support of the voluntary prepaid programs by all physicians and the need for real activity on the part of physicians in this year's political and election campaigns.

In order that Ohio physicians may have an opportunity to form their own opinion of Dr. Hawley's controversial talk and in the hope that it will at least arouse the medical profession here in Ohio to more activity in public relations, political activity, and in support of the voluntary medical and hospital programs now functioning in Ohio, *The Journal* presents the complete text of Dr. Hawley's address, reading as follows:

* * * *

TEXT OF HAWLEY ADDRESS

The dangers that threaten the free practice of medicine in this country are fast becoming critical, and still we delay in uniting in decisive action to meet them.

We waste precious time in quarreling among ourselves over petty questions of local sovereignty. We amuse ourselves by setting up fantastic straw men, and dissipate our energies in knocking them down, while our enemies have been uniting against us in one national effort. We have thus far done no more than fight a series of rear-guard actions with small unorganized and uncoordinated groups. I know of no more certain road to disastrous defeat.

Our national leaders seem to be purposefully blind to the social changes that are taking place. It is impossible to halt a movement by merely refusing to recognize its existence; and this movement toward extending the benefits of adequate medical care to all of our citizens has

already gained too much momentum to be halted by any means. The last hope of American medicine lies in abandoning our present position in the rear of the column, where we have been holding back, and establishing ourselves firmly in the forefront, where we can guide and direct the movement into paths that are the best for our people as well as best for our profession. I emphasize that the welfare of our people must be given at least as much consideration as the welfare of the health professions. Too many physicians regard medical care as their exclusive prerogative. We must recognize that the consumer of medical care also has a great stake in it; and, if there has existed any doubt as to this, it should have been dispelled by the deliberations of the National Health Assembly, held in Washington early in May.

RE: NATIONAL HEALTH ASSEMBLY

I shall offer no defense of the motives that prompted the organization of this Assembly. They may have been, as has been charged, largely political. But however impure the motives, only a very stupid person could have listened to the discussions in the Section on Medical Care and come away unimpressed both by the strength and the determination of the groups committed to an effective program for prepayment of medical care. I emphasize "effective," because the preponderant opinion there expressed was that existing plans are acceptable only so far as they go, that they do not go far enough, and that, if they are to be fully acceptable as a substitute for compulsory government health insurance, the coverage they offer must be extended considerably, and must be uniform throughout the country. In fact, a resolution to the effect that only a compulsory government insurance plan could satisfy these criteria was proposed, and vigorously supported by the American Federation of Labor, the Congress of Industrial Organizations, the Cooperative League of America, the National Cooperative Health Federation, the National Federation of Settlement Workers, the Committee for the Nation's Health, the American Association of Social Workers, the Physicians' Forum, the National Consumers' League, the National Women's Trade League, the United Mine Workers, the American Veterans' Committee, the National Farmer's Union, the Physicians' Committee for Improvement of Medical Care, the League for Industrial Democracy, and the Association for the Advancement of Colored People. This conclusion was not adopted, for the reason that adoption of any conclusion required the unanimous approval of the Steering Committee; and a single dissent was sufficient to defeat a proposal. But the array of strength behind this conclusion should convince even the die-hard Tories in the health professions that the threat of nationalization of medical care in this country is real, is acute, and soon will be, if it is not already, sufficiently great to precipitate action by the Congress. The press carried yesterday the news that the Wagner-Murray-Dingell Bill would not be reported out of Committee during this session of the Congress; but it also stated that hearings upon this Bill would be resumed in March, 1949. So the Bill is far from dead. The representatives of the people, in Congress assembled, are swayed by numbers of voters rather than by principles. Even discounting the smaller and the more radical groups demanding national health insurance, we still have the A.F. of L., the C.I.O., the Na-

tional Women's Trade League, the United Mine Workers, and the Association for the Advancement of Colored People demanding national health insurance. These represent a lot of votes. I am sure they represent more votes than have yet been mustered in favor of equal rights for Negroes, and look what has been accomplished in this direction within a very short time! If this array of political strength is not enough to shock the medical profession out of its lethargy, then we are hopelessly lost and there is no use continuing the struggle.

WHAT OF THE FUTURE

What, then, will be the future of the voluntary prepayment plans for medical care—both commercial and nonprofit? Those demanding national health insurance were generous enough to state that the voluntary plans should continue in operation after the inauguration of national health insurance. This, of course, was but a courteous gesture since it would be impossible for voluntary plans to compete with a government plan. The handicap would not be one of cost, because the voluntary plans can do the job cheaper than the government can. But the fact that the government plan would be supported at least one-third by tax money, and that everyone would have to pay this tax, whether or not he subscribed to a voluntary plan, would dissuade the taxpayer from supporting two plans at the same time.

Since it is impossible for voluntary plans to survive if and when national compulsory health insurance comes, we are going to have one or the other type of prepayment health insurance—not both. So, the future of the voluntary plans depends entirely upon the prevention of the enactment of national compulsory health insurance legislation.

This cannot be prevented through political manipulation. It is my considered opinion that, if left to popular vote, this legislation might pass today. Certainly the strength mustered in its support at the National Health Assembly surprised even its protagonists—and was something of a shock to me.

CAN BE PREVENTED

But this disastrous legislation can be prevented if the voluntary plans meet every reasonable demand for health insurance. I specify "reasonable demand" because, as all of us know who are familiar with the problems involved, some of the demands expressed at the National Health Assembly are impossible of fulfillment at the present time, and for some years to come.

There were unanimously adopted by the Medical Care Section seven criteria for measuring the effectiveness of prepayment plans in meeting the medical care needs of the people. I shall discuss only the more important of these as they point the goals which must be reached by voluntary prepayment plans if they are to be considered adequate to the peoples' needs.

SUGGESTED GOALS

The first criterion is "The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury." To meet this criterion, voluntary plans must be in a position to offer as comprehensive a coverage as the public demands, regardless of cost. Since many people, neither desire so complete a coverage, nor

are willing or able to pay its cost, this means that plans will have to offer more than one type of contract. This will not be at all difficult once a competent actuarial service is established. I can think of no good reason for limiting the offering of a prepaid medical care plan to a single type of contract. We must always, of course, offer a contract that is within the economic reach of the low-income groups who must bear all or part of its costs. But these large union groups are demanding a much more comprehensive service, and are willing and able to pay for it. We simply must be in a position to offer them a contract that meets their requirements, or we shall not only be forced out of business but also we shall have compulsory government health insurance as a reality instead of as a threat.

The fact that the fee schedules for the low-income group contracts are inadequate for the higher-income contracts need give no physician any concern. It is quite easy to arrange a separate fee schedule for each type of contract. For the higher-income groups, the fees should be higher, and should correspond to the fees normally charged such groups. The wealthier groups expect that—in fact, I am sure that they would demand it, because they do not want to be regarded as charity patients—and they are willing to pay the additional premium for their coverage.

What can it matter to the participating physician whether the patient pays the bill from his private income, or whether the bill is paid by the medical care plans, so long as the amount paid corresponds with the fee customarily charged in that income level? Even if there is some objection to such a procedure, the alternative is to lose millions of potential patients to employee-benefit associations and medical cooperatives operating their own clinics and hospitals. I cannot stress too strongly the fact that this movement has already reached the point where the medical profession has the choice only of making a reasonable effort to meet the requirements of these large groups of consumers of medical care, or of watching the private practice of medicine in this country being rapidly strangled by either cooperative or government medicine. No other alternatives are left. All other alternatives have been lost in the ten or fifteen wasted years in which organized medicine has pursued an entirely negative course in dealing with this social problem.

WANT UNIFORM COVERAGE

The next point of the greatest importance is that these large groups will not be satisfied with anything short of uniform coverage for their members regardless of their place of residence. They simply will not deal with 51 separate Blue Shield plans. Already the United Mine Workers, with 400,000 members, have a 10-cent per ton levy solely for health and welfare. As we assemble here, a union with more than 1,000,000 members is negotiating with a large industrial corporation for a 10-cent per hour increase in wages, to be devoted exclusively to a health and welfare program. Another union, with more than 1,000,000 members, has already appointed a medical advisory council to formulate a prepaid health program for its members, to be paid for by a similar 10-cent per hour raise in pay.

CRITICIZES MEDICAL LEADERS

Is organized medicine guiding and directing these programs? It is NOT! I happen to know

some of the members of this medical advisory council of this gigantic union. I can tell you that they are openly committed to government compulsory health insurance. Let me give you the names of some of them—Fred Mott, who is directing the government medicine program in Saskatchewan; Dean Clark, who is director of H.I.P. in New York; Jack Peters, who is Secretary of the Committee of Physicians for the Improvement of Medical Care. I can tell you further that the plan for the medical care of this large union, which was proposed at the first meeting of this medical advisory council, was similar to that of the Health Insurance Plan of New York—the establishment of clinics in every center of this union population, and these clinics to be operated by salaried physicians. This Association is on record as opposing such a plan for medical care.

Why was not organized medicine approached for advice and counsel in the establishment of these huge programs for prepayment of medical care? I'll let you answer that question. But doesn't it shock you, doesn't it give you a feeling of insecurity that the leadership of these great movements, which will exert the most profound effect upon medical practice in this country—that the leadership in these movements has slipped from the grasp of organized medicine? I can tell you that it disturbs me deeply, and that I am convinced that the cause is lost unless you take prompt and effective action to regain control of medical practice in this country. I say "regain" because I am afraid you have already lost it, whether you realize it or not. And you are not going to regain it through the methods you have followed during the past ten years.

CONFERENCES WITH LABOR

Some three weeks ago I had a conference with one of the most powerful, if not the most powerful, labor leader in the United States. This organization, of which he is the President, controls many labor unions with millions and millions of members. He has already started this movement for a prepaid medical care program in two of his largest unions, and he assured me that it would be carried on throughout the labor empire that he controls. I am violating no confidence when I tell you that he exhibited a strong bias against the attitude that organized medicine has displayed up to the present moment. His closest welfare advisers made it very clear to me that they would deal with the voluntary nonprofit prepayment medical care plans only if these plans met their requirements to a reasonable degree. They did not display an adamant insistence upon 100 per cent performance at once but they set forth a few principles upon which they would not compromise.

The two most important principles upon which they would insist in full were uniform coverage in every area in which their members reside, and a single contract with one labor-management board regardless of the number of individual medical care plans which would be involved in providing the service. There would be no negotiation with reference to these two principles—we would have to accept them or reject them as they stand.

These gentlemen also made it clear that they were opposed to indemnity insurance and would accept this type of contract only as a temporary expedient. They are committed to the principle of the service contract.

These requirements can be met, and met

easily. But they cannot be met so long as our vision is limited by the boundaries of the small areas in which we live and practice medicine. The problem is one of national scope, and it cannot be solved by State and County Medical Societies acting independently. I can assure you that you will not even be listened to, much less dealt with, upon any such basis.

NATIONAL AGENCY PROPOSED

Neither one of these requirements can be met, however, without the necessary machinery at the national level of Blue Shield Plans. You know full well that it would be impossible for 51 separate Blue Shield Plans to get together around a table and agree upon a uniform contract. Even if this were possible in one case, you must remember that different groups may demand different degrees of coverage, and this painful process would have to be repeated each time we were approached by a national group. The time required to effect such agreements would defeat us. These prospective clients demand an answer within days—not months.

For these reasons, only a National Service Agency, controlled by all the participating Blue Shield Plans, can possibly meet this urgent need. My own concept of such an agency is this:

1. It would be controlled by a board of directors elected by the participating Blue Shield Plans.
2. It would underwrite medical care programs of national scope; and, in turn, would pass on to each local plan concerned the share of the business that lay within the area of that plan.
3. If any local plan desired to accept the entire risk of additional coverage offered in any contract, it would be free to do so. If, on the other hand, any local plan declined to carry the additional coverage demanded, the National Service Agency would carry the added risk, and pay the local plan for all such service rendered.
4. The National Service Agency would work **only** through local plans. It would write no contracts in any area covered by a plan that did not involve two or more plans, and it would offer no contract of itself except in areas not covered by any Blue Shield Plan.
5. The National Service Agency would have no control over any local plan other than to see that agreements entered into with subscribers were carried out.
6. The existing organization of Associated Medical Care Plans would not be disturbed. The National Service Agency would be an underwriting organization, and not one of control.

SEES NO DANGER

As a physician, who is intensely interested in the future of medicine in this country, I cannot see the slightest danger in such a project. Each local Blue Shield Plan would preserve its present degree of autonomy, and the national agency would be one that served all the plans rather than one that controlled all the plans. And, don't forget one thing—it is either some such arrangement or be forced out of business. If we are not going to be in a position to serve these new millions of organized consumers of medical care, we had better announce that fact right now and liquidate our Blue Shield Plans. Sud-

den death is much preferable to a lingering, painful death; and slow death for us is certain—and maybe not so slow at that—unless we get in step with the rest of the country.

I mentioned earlier that straw men were being set up so that they could be knocked down. Perhaps the largest of these straw men is that this is just a scheme for Blue Cross to gain control of medical practice in this country. This is not only the largest of the straw men, it is also the most fragile. I work just as closely with the Blue Cross Commission as I do with the Blue Shield Commission. I have not seen the slightest evidence of any desire—much less, intent—on the part of the Blue Cross Commission to exert even the slightest control of the practice of medicine. The cry of "No Merger" has been raised against the two Commissions. I have been instructed by the Joint Executive Committee of the two Commissions to state that merger of Blue Cross and Blue Shield has never been considered. All that has ever been seriously proposed is a federation of the two groups for the single purpose of promoting the success of both. The leaders in Blue Cross believe, just as do the majority of leaders in Blue Shield, that we must effect enough cooperation between these two great organizations for us to offer prepaid medical and hospital care in one package. The public cannot understand why they should be forced to join two different organizations to protect themselves against the cost of illness—and, when you think of it, it is hard to explain. But joining hands solely for the purpose of offering prepaid health protection in one unit is a far cry from merging the two organizations under single control.

I beg of you not to be misled by any such vicious propaganda. So long as I remain in this position I shall defend medical practice just as zealously as I uphold the principles of Blue Cross. If there were any real areas of conflict between these two organizations, I would certainly discover them at once; and I can find none.

You did me the great honor last year of inviting me to address you at Atlantic City. I spoke to you very frankly at that time, pointing out the dangers to American medicine from within. That the majority of you approved my remarks, and believed in my complete devotion to our medical profession, is indicated by the fact that you have again invited me. I doubly appreciate this present honor; and I am again forcibly reminded of my great responsibility to the medical profession. I shall not, in the slightest, shirk this responsibility nor shall I ever compromise with my obligation to American medicine.

RAPS INDIFFERENCE

But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who would rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest.

If we get socialized medicine in this country, it will be organized medicine, and only organized medicine, that has brought this curse upon us. We, as physicians, will have only ourselves to blame. If I were among the group that wants socialized medicine in this country—if I were Channing Frothingham, or Ernst Boaz, or Jack Peters, or Michael Davis, or Isidor Falk—I would

not exhaust much energy in making a great personal effort—I would relax and let organized medicine do the job for me. All that is necessary to bring socialized medicine to this country within a very short time is for organized medicine to pursue the same course that it has pursued for the past ten years.

The demand for more comprehensive medical care, and for an effective means of budgeting its costs, has grown, within ten years, from a whisper to a roar. Our people will not be denied much longer. If the medical profession does not at once assume the leadership, if it does not at once cease its double-talk and double-dealing with the voluntary nonprofit prepayment plans, and throw its influence squarely and honestly behind these plans, we are going to have compulsory governmental health insurance in this country within three years.

SAYS TIME IS SHORT

I give free medicine a lease on life of three years solely because other heavy financial commitments of the government will preclude the assumption of the additional burden of compulsory health insurance. The Marshall Plan and the rearmament program will keep the government, and the taxpayers, strapped for the next few years. But, within three to five years—and I think it will be nearer three—either these measures to restore peace will have been successful, or we shall again be in a war. I believe we shall have peace; and just as soon as the taxpayer is relieved from this terrific burden of his investment in peace, you may be sure the politicians will be ready to impose upon him the burden of a compulsory health insurance program—that is, unless by that time we have demonstrated that voluntary health insurance is a completely satisfactory answer to the problem. And I would emphasize further that, if we start right now, it will take at least two years to effect an organization that can do this job. We cannot afford to waste any more time in fruitless discussions that lead us nowhere. We must decide right now whether we are going to unite in this effort; and, if we are, we must cease all delaying and obstructive tactics.

Don't be lulled into a sense of security by such able studies on socialized medicine as have been made by the Brookings Institution, and the National Industrial Conference Board, and other capable agencies such as these. Of course, every thinking person is convinced that socialized medicine would be a great mistake—a costly mistake both in money and in health. But this issue will not be decided by wisdom. It will be decided entirely by emotion. Like President Coolidge's preacher, who was "agin sin," everyone is against sickness and death. Only a small minority of our people can understand the dangers of socialized medicine—all they know is that they want everyone to have good medical care, and they are not capable of choosing between the various ways in which medical care can be better distributed. Only a "fait accompli" will convince them—and so we have only a short time in which to show them an accomplished fact.

It is useless for the medical profession to undertake the education of our people to the dangers of socialized medicine. Our public relations have been so miserable in the past few years that a majority of our people suspect us of having only a selfish, personal interest in this question. I honestly believe that the medical

profession does more harm than good when it attempts to decry socialized medicine—our motives are too suspicious.

SAYS "STRIKE" IDEA ABSURD

Don't be misled with such absurdities as the assurance that the government cannot make you practice medicine if you do not want to. You see what has happened in England. The members of the British Medical Association voted at first to have nothing to do with government medicine. The majority was heavy—80 per cent pledging themselves to remain outside the government plan. But, as the deadline for participation approached, British physicians, by a small majority, voted to accept the government plan.

How long can you hold out in a strike against the government? How many of you could stick it a year with no income? And how many of you would stick it if you saw a minority group collecting all the gravy? You are trained in medicine. How many of you would be willing to forsake medicine and embark upon another career?

Don't let anyone fool you! If government medicine comes, 90 per cent of you will be forced by circumstances to accept it, no matter how bitter a pill it will be for you to swallow. So, the only way to prevent this tragedy is to stop it before it arrives—there is little you can do about it after it comes. The medical profession can prevent this tragedy, but only by positive action that will meet the reasonable demands of these large groups. Consistently negative action has brought us to this critical juncture, and has played directly into the hands of the enemies of free medicine. Time is running against us. We cannot longer delay.

This convention, which is about to open, promises to be the most important in the hundred years of existence of the American Medical Association. The great work of the past hundred years can be undone overnight by unwise action during this week. I beg of you to weigh carefully the issues that will be presented. I ask you to weigh them in the light of the events of the past few weeks. I am as certain as I am that I stand here that, if this convention fails to encourage and support the expansion of the Blue Shield movement, the death knell of free medicine in this country will have been sounded.

Diamond Jubilee of Nursing

President Truman, ex-president Herbert Hoover, and Senator Arthur H. Vandenberg, heading a committee of 70 leaders in public life, have joined with the American Nurses' Association in sponsoring the Diamond Jubilee of Nursing which will be marked by celebrations throughout the country.

According to Pearl McIver, A. N. A. president, it is hoped that the Jubilee will effectuate the recruitment of the 40,000 additional students for approved schools of nursing desperately needed, if professional nursing needs are to be met. She said that a coast-to-coast program of activities highlighting the history and progress of nursing to the present day, and paying tribute to the 320,000 registered professional nurses of America, will be initiated during Nursing Progress Week, November 14 to 20.

National Health Program . . .

A Brief of the Proposed Ten-Year Government-Sponsored Plan, Including Compulsory Health Insurance, As Submitted by Mr. Ewing

THE Nation's Health—A Ten-Year Program," a report prepared at the request of President Truman by Federal Security Administrator Oscar R. Ewing, was released to the public press early in September.

The report is an attempt on the part of Mr. Ewing to evaluate the Nation's total health resources and recommend a basic Federal-state-community action program for meeting health needs during the next ten years.

An integral part of his recommendations is the institution of compulsory government health insurance. Members of the medical profession obviously will disagree with some conclusions drawn by Mr. Ewing. On the other hand, however, the report is a revelation of one very persistent and strong school of thought on national health, and points up some of the obvious and admitted weaknesses in the nation's health setup. It should be read by all physicians.

A copy of the report may be obtained by sending \$1.00 to the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

The report, according to Mr. Ewing, draws heavily upon the findings and recommendations made last May by the National Health Assembly, a forum of more than 800 professional and community leaders called together to make studies and recommendations concerning all phases of the Nation's health problems. The author of the report, in all fairness, however, states that he deviates from the recommendations of the Assembly in some instances.

The following is an unbiased summary without editorial comment of the 186-page report, with exact quotations from the text of the report. (Emphasis is added in the form of bold faced type merely to draw attention to certain points of interest.)

FOREWORD

"I would like to make it clear that I have weighed carefully every finding and recommendation of the Assembly. To the issue of health insurance, I have given particular time and thought. The Medical Care Section of the Assembly unanimously agreed that 'the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people.' **There was no agreement on the question of national health insurance** and my recommendation of such a program must be clearly understood as

in no way expressing the views of the Assembly. **It took no position, one way or the other, on this question.**

" . . . The arguments that have been made against national health insurance have been carefully weighed and I still find myself compelled to recommend it. After all, we are dealing with human lives and human suffering and anguish. Every year, over 300,000 people die whom we have the knowledge and skills to save. This stark fact proves that the present system is inadequate. By and large, only the well-to-do and, to a certain extent, charity patients get satisfactory medical care. The in-between groups—other than the fairly small portion who are covered by voluntary insurance plans—are the ones desperately in need of better care. I see no possible way to provide funds needed for adequate medical services to these in-between groups, who constitute the vast majority of our people, except through a system of national health insurance.

"The success of the National Health Assembly as a forum suggested to me **the value of holding similar state and local assemblies throughout the country** to exchange information and opinion, and to organize health work."

HEALTH OF THE NATION

During the last generation, the United States steadily improved its health record, but the Nation, and the people, still suffer severe losses through sickness, disability, and death, much of which is unnecessary.

Every year, the Nation loses 4,300,000 man-years of work through bad health.

Every year, the Nation loses \$27,000,000,000 in national wealth through sickness, and partial and total disability.

The record of Selective Service examinations during the war is widely known—5,000,000 men declared unfit physically or mentally for the armed services of their country.

We know also that our armed forces create special demands for medical manpower; that a national emergency would throw an intense strain on our entire health system.

But the record, good as it is, leaves plenty of room for improvement. Of more than 3,800 deaths that occur daily in the United States, nearly 900—about 23 per cent—are preventable. Much of the sickness that cuts down the efficiency

of the Nation's working force can also be prevented.

KIND OF SERVICES REQUIRED

The types of services and care that must be made available to every person in the United States if we are to attain the highest level of national health are:

Medical and dental care—Enough manpower that essential services should be available to everyone in a health center or hospital clinic, in offices, the home or wherever care is needed.

A healthful community—Every town, city, rural area should be guarded by a well-staffed public health department.

A community clinic—It will be particularly important for smaller towns and rural areas to have a publicly owned facility.

A community hospital—A hospital large enough to care for all births and other ordinary hospital needs, so placed that no one in the county is more than an hour's easy travel from it.

A district hospital—In urban centers to which local residents have direct access, and residents of surrounding communities may be referred.

Special hospitals—For chronically ill, convalescent, etc.

A medical center—At least one in every state, preferably associated with a medical school, where research would be carried on and medical personnel trained.

Coordination—Organization of the previously mentioned units.

A prepayment plan—A system of insurance should make it possible for everyone to have comprehensive care without worrying about meeting sudden bills out of current pay.

In addition to our special efforts for the attainment of health, we must assume contemporaneous and parallel efforts to assure: (1) A steadily rising standard of living, assuring better nutrition, recreation, and other contributions to healthful living; (2) better educational systems—in number and quality; (3) increased benefits for the aged and permanently disabled so that their minimal essential economic needs are provided for; (4) adequate housing for the people of this Nation; and (5) increased understanding on the part of the people of benefits of scientific medicine and public health methods.

It is important to point out certain limiting principles that must apply to any national program. Realizable health goals will vary, not only among individuals and groups, but among states and communities. No single set of health goals can be reached by all of the people and in all parts of the country in the next ten years. Plans for the attainment of health goals must be varied according to the relative needs and resources of various parts of the country.

In the past our economy has measured the adequacy of health and medical services generally

by the criterion, "Is there enough to satisfy the purchasing power of the consumers?"

We must measure our resources and services against the actual health and medical needs of all the people, without regard for their individual ability to pay.

A scant 20 per cent of our people are able to afford all the medical care they need. About half our families—those with incomes of \$3,000 or less—find it hard, if not impossible, to pay for even routine medical care. Another 30 per cent of American families with incomes between \$3,000 and \$5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness.

Success in our efforts for health will depend ultimately not only on Federal action but also on individual, community and state achievement, and upon the thorough and wholehearted cooperation of all interested groups and individuals.

MANPOWER

The expansion of training schools, at an average rate of not less than 5 per cent per year in annual production, should accomplish the following by 1960: (1) Increase our present supply of 190,000 active physicians to 227,000; (2) increase our present supply of 75,000 dentists to 95,000; (3) increase our present supply of 318,000 nurses to 443,000; (4) increase our supply of other supporting personnel by comparable proportional amounts.

The goal is to double the number of acceptable hospital beds as rapidly as possible, certainly within 15 years, and, at the least by 1960, to have added 600,000 beds to our hospitals, and build such additional health centers and auxiliary facilities as state-by-state surveys have shown to be necessary throughout the country.

FINANCING THE PROGRAM

The value of all goods and services, including wages and salaries paid, amounted to \$230,000,000,000 in the United States last year. About 60,000,000 people were employed, so each one produced an average of about \$3,800 of the total. By applying this figure to days absent from work because of illness, total or partial disability, we can get a round idea of our national losses.

The category called "short-term sickness" includes all absences because of sickness or injury that last from one day to six months. During 1947 the total loss of time from these causes averaged six days per worker. At 1947 rates of production, short-term sickness cost the Nation at least \$5,000,000,000 in lost production and wages.

Workers incapacitated because of chronic diseases, accidents or other causes cost \$11,000,000,000 in lost production and wages. The loss from partial disability is about the same.

The nation thus lost \$27,000,000,000 during

1947 in potential production and wages through sickness, partial and total disability. We have not taken into account the losses occasioned by premature deaths. Retirement programs generally stipulate 65 as the age of retirement. Any death that occurs before this age may be considered premature. On this basis the total loss for 1947 was more than 27,000,000 life-years.

TO REDUCE LOSS

Against these losses in production and wages, which last year amounted to more than 10 per cent of our national total, the Nation as a whole spent—from public and private funds—a trifle more than three per cent, or approximately \$8,500,000,000, for medical and health services.

Of this, the local, state, and Federal governments expended \$1,962,000,000 for medical care and prevention, including the entire health program for veterans. Private individuals and organizations spent the rest—\$6,500,000,000.

To make a beginning on reducing these human and material losses due to bad health, I have proposed a gradual expansion of health services and resources. This will involve, financially, an increase in spending by local, state, and Federal governments, and the institution of a prepaid system of government insurance.

Medical care for the needy outside of hospital and other institutions at present costs the Nation about \$150,000,000 a year. Under the assumption that welfare agencies would pay premiums for the needy at the average per capita rate into the insurance funds, this total expenditure would probably be reduced by nearly 50 per cent to \$80,000,000, divided among Federal and state and local agencies. . . . Probably some subsidies—about \$25,000,000 a year—would remain necessary in 1960, when insurance coverage may still be incomplete.

Government expenditures for civilian health on this basis would represent about 1.6 per cent of a total personal income of \$250,000,000,000—a reasonable expectation for 1960—and would still constitute a negligible proportion of the amount the Nation loses every year through ill health.

FIRST HEALTH GOAL

“To increase our supplies of medical manpower until there is enough everywhere in the country to satisfy the health and medical needs of all the people; to do this by expanding and establishing medical colleges, training schools and teaching hospitals until, by 1960, our annual production of medical manpower in all categories has increased by 40 to 50 per cent.”

For normal times, an entirely realistic standard is based on levels of medical manpower al-

ready attained in our own country by the 12 states at the top of the ladder.

The 12-state yardstick for physicians—the average of the top quarter of our states—is one for every 667 persons. On this basis, applied throughout the Nation, we will need 254,000 physicians by 1960. Our present prospects are for only 212,000 by that date.

The 12-state yardstick for dentists is one dentist for every 1,400 persons. By this standard we will need 113,000 by 1960. Our prospects are for only 90,000.

The 12-state yardstick for nurses, both professional and practical, is one for every 280 persons. By this standard we will need 566,000 nurses by 1960. Our present prospects are for only 403,000.

Negroes comprise 10 per cent of the total population but produce only 2 per cent of the country's physicians.

In 1947 the American Psychiatric Association reported only 4,500 certified psychiatrists. There is a need for at least 15,000.

We have only about 3,500 pediatricians. We need at least three times that figure.

SECOND HEALTH GOAL

“To assure that there are enough hospital beds of all kinds everywhere to meet the people's needs, and to finance hospitals so that they may give the highest quality services; to accomplish this by doubling the number of hospital beds, adding at least 600,000 by 1960; by building such auxiliary health and community centers as are needed, particularly in rural areas; and by uniting hospitals and centers into regional chains so that the most remote regions will have full access to modern and scientific medicine.”

We have only about 900,000 acceptable hospital beds, outside of Federal hospitals, in the entire country, against established need for twice that number. At an average estimated cost of \$10,000 per hospital bed, the total cost of meeting our goal for hospitals is in the neighborhood of \$9,000,000,000.

Under the Hospital Construction Act the Federal Government is contributing \$75,000,000 a year to build hospitals. If fully expended and matched with \$150,000,000 of local funds, this program will permit the Nation to build about one-eighth of its total needs by 1951. At this rate of building, we will meet 1946's needs in 1986—40 years too late. Private hospital construction cannot possibly fill the gap.

RECOMMENDATIONS ON SECOND GOAL

“That the minimum Congressional appropriations for hospital construction for the next two years should be at least \$150,000,000 annually, which is double the present authorization of

\$75,000,000 a year, plus such additional funds as are necessary to increase the Federal share of construction costs in areas of greatest need.

"That as soon as possible, but certainly by the end of the first five years' operation of the amended Hospital Construction Act, Federal funds should be increased so as to finance the addition of 600,000 beds to our hospitals by 1960 and 900,000 beds within 15 years.

"That the Federal government should provide up to 40 per cent of construction costs, beginning in 1949, and should encourage states to provide another 40 per cent to the end that impoverished areas will have to finance only 20 per cent of original costs.

"That the Federal government, beginning in 1949, underwrite up to 40 per cent of the maintenance cost of hospitals in selected areas of low per capita income for as long as such subsidies are needed.

"That all maintenance subsidies to hospitals be assured only on condition that professional personnel should be accepted as staff members, or as workers, in the underwritten hospitals without discrimination as to race, religion, or sex.

"That Federal funds be made available to assist the states with administrative expenses under the Hospital Survey and Construction program."

THIRD HEALTH GOAL

"To assure that every individual without regard to his economic status has full access to adequate medical services for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical and mental health."

From the financial standpoint, the chief barriers to adequate care and service include: (1) The increased cost of modern scientific medical care; (2) the irregular and unpredictable occurrence of sickness and of the costs of medical care, when bills are paid out of pocket by the individual on a fee-for-service basis; and (3) the low incomes of many individuals and low income levels of many communities.

The percentage of families in various income brackets during 1946 was as follows: Gross cash income of \$1,000 or less, 12.8 per cent; income \$1,000 to \$2,000, 15.4 per cent; income \$2,000 to \$3,000, 19.5 per cent; income \$3,000 to \$5,000, 31.4 per cent; over \$5,000, 20.9 per cent.

In the light of these facts, it is clear that close to 70,000,000 people will have difficulty in providing adequate minimal care for themselves and their families. The difficulty will, of course, be greatest for those at the bottom of the scale. People with incomes above \$3,000 will probably be able to purchase minimal care.

It is self-evident that there is no such thing as "free" service. Health care, like everything else, has to be paid for by someone—by the individual, by taxes, private or institutional philanthropy or public subscription.

There is a strong temptation to believe that the only solution of the problem lies in the bigger and better national income, better distributed throughout the population. The truth is that even this gradual accomplishment would not satisfy our national health needs. The people in the lower half of the income scale would still not be able to buy what they needed. Communities with lower per capita incomes would still not be able to support professional personnel and health facilities adequate to the needs of the people.

The present methods of paying for medical care have served us well in achieving the present level of health, but the evidence cited in this report shows that substantial further improvement demands new methods. **First steps toward a better system of payment have been taken already under voluntary health insurance plans.** For millions of people, these systems have made it possible to purchase a larger share of their health needs.

VOLUNTARY OR GOVERNMENT INSURANCE

A satisfactory system of health insurance should provide: (1) That everyone should have ready access to adequate health and medical services; (2) that everyone should have the kind of services and all the services, he needs to promote better health; (3) that everyone should be able to obtain these without regard for the level of his personal income.

Obviously, these criteria go far beyond the intent of any voluntary insurance plan. The objectives of such plans are confined, by and large, to making it easier for some people to meet some of the expenses of medical care, chiefly hospitalization.

About 25,000,000 people—17 per cent of the population—have insurance for actual services in hospitals, usually only for a limited number of days.

About 20,000,000 more people have policies for cash reimbursement of certain hospital bills, leaving part of the costs and services uninsured.

Only about 3,500,000—less than three per cent of the population—have anything approximating comprehensive insurance protection that includes hospitalization and also doctors' care in office, home and hospital. In most cases, even these policies do not include such necessary items as dentistry, home nursing, expensive drugs, and such appliances as eyeglasses or hearing aids.

In addition to these 3,500,000, some 16,000,000 or 17,000,000 people—nearly all of them in-

cluded among those covered by hospital insurance—have protection against part of the costs of some physicians' services, usually restricted to hospitalized cases.

Enrollment for hospitalization plus surgical benefits has spread mainly among industrial and commercial employees. About 60 per cent of all Blue Cross hospital plan members live in six rich industrial states that contain about 36 per cent of the total population. In the South and West, which have 43 per cent of the population, Blue Cross can count only about 17 per cent of its members. Its enrollment is predominantly among city people employed in commerce and industry. Less than three per cent of the rural population are subscribers.

One factor that requires limitations on benefits is the flat-rate premium charged by nearly all voluntary insurance plans. The benefits will continue to be limited to what can be covered by the premiums paid in by the group.

The cost of insurance—the flat-rate premium—undoubtedly places a ceiling on the number of persons who may be enrolled ultimately in voluntary insurance plans. It is extremely unlikely that any family of two or more persons with an income below \$1,000 will be able to pay an insurance premium of \$48 to \$72 a year. Most of the 22,000,000 people in families with incomes between \$1,000 and \$2,000 will be able, with hardship, to pay for some medical care. It should be pointed out, in this connection, that 70 per cent of all farm families had gross cash incomes in 1945 of less than \$2,000; and 42 per cent less than \$1,000.

It is apparent that on a flat-rate basis, the voluntary insurance plans can never enroll any appreciable proportion of the 18,000,000 people in families with incomes below \$1,000 even in the limited hospitalization and surgeons' fees type of plan. The additional 22,000,000 in families with between \$1,000 and \$2,000 are almost all in the same positions. Probably 20,000,000 more in families with between \$2,000 and \$3,000 will remain outside the protection of the plans. If insurance benefits are broadened enough to provide reasonably adequate care, the premiums are even more out of reach for all this group and will be prohibitive to many who earn even more.

This examination of the facts makes it clear that, at a maximum, only about half the families in the United States can afford even a moderately comprehensive health insurance plan, on a voluntary basis. The net result, then, would be to leave without adequate protection the very groups—those with income below \$3,000—whose plight the Nation needs most to remedy in order to raise the country's level of health.

The limitation that lack of income places on expansion of voluntary insurance plans becomes even clearer when the coverage is matched with the per capita income levels of the various states. The spread of hospitalization insurance plans generally follows the same distribution pattern as the supply of doctors, hospitals, and other health services.

A WAY TO IMPROVE HEALTH

There are many earnest people in the country who sincerely urge that we go ahead as we have in the past. They point out that the American health is equal to the best in the world; they feel that it is dangerous to make any basic change in the system that has produced this achievement.

"I cannot accept this thesis. We can improve the Nation's health markedly. What was good enough 30 or 40 years ago, no longer is adequate."

A GOVERNMENT INSURANCE PROGRAM

The prime objective of any plan for prepaid government insurance for medical services would be the improved health of the people. It would accomplish this objective in two ways: (1) By eliminating the financial barrier between any person and the services he needs to promote better health; and (2) by stimulating the development of more nearly adequate supplies of health resources and their equitable distribution throughout the country—doctors, nurses, hospitals, and other services—through the assurance that there will be a steady and effective demand for those health services.

The logical sequence of events for accomplishing these ends would fall into this pattern of four phases:

Phase One—Federal legislation to settle the basic policies of a system of government insurance to decide important details; and to provide for a three-year "tooling-up" period before the date on which insurance benefits are made available.

Phase Two—The tooling-up period, during which procedures would be worked out cooperatively by professional groups, localities, state, and the Federal government; agreements arrived at with individuals and groups providing medical services; and the machinery for actual operations set up.

Phase Three—Operations begin, services are provided up to the ceiling set by resources as they exist at the time.

Phase Four—Expansion of services, as the accelerated increase and improved distribution of medical manpower and facilities lift the

ceiling, until comprehensive services are available to everyone, everywhere in the country.

PHASE ONE—LEGISLATION

The following 12 points indicate some of the major items for legislative action in a Federal law setting up a system of government insurance:

1. **Objectives**—The law would furnish policy guides to the public, provide for services and administration.

2. **Coverage**—The law would determine who would make prepayments and who would receive benefits. The coverage should be as broad as possible.

3. **Premiums**—It is fundamental that rates should be based on individual ability to pay—that is, be established as a percentage of earnings instead of as a flat rate.

4. **Benefits**—The benefits should be as comprehensive as possible with only such limitations as may be unavailable at the beginning. It should be clearly specified that the benefits are to be administered through Federal-state-local cooperation, with the major emphasis on administration at the state and local levels, so that the keynote is decentralization and local participation. It should be equally clear that payment for services provided through physicians, dentists, nurses, laboratories, and hospitals would be made at rates and by methods mutually agreeable to them and the insurance system.

5. **Guarantees to Insured Persons**—The law should give explicit guarantees to insured persons and their dependents, including guarantees as to their rights to benefit solely by reason of their insurance; their right to make free choice—individually or in association with other insured persons—of physician, dentist, hospital, etc., and to make a change in that choice; their right to have their personal records kept confidential, to be protected against discrimination, to make complaints or appeals before appropriately constituted committees, and to have recourse to court review of administrative decisions which they believe are unfair.

6. **Professional Freedoms**—The law should give equally explicit guarantees to the members of the professions who provide services, including the right to participate in the plan or not, to act individually or in groups, to accept or reject patients who choose them, to retain control of professional aspects of professional service, to choose the method of payment for services rendered, to negotiate rates or amounts of payment and other matters through representatives of their own choosing, to make complaints or appeals before appropriately constituted committees, and to turn to the courts for review of administrative decisions. Such guarantees would preserve the essential freedoms of the professions and assure that they could not be "regimented" by administrative officers.

7. **Benefits for Rural People**—The law should make special provisions to meet the needs of rural areas and the urban centers which serve them.

8. **Education and Research**—Support of professional education, postgraduate training, refresher courses and research should be provided.

9. **State and Local Administration**—Since the benefits would be provided in local areas under state plans, the law should state the minimum conditions to be observed by states and localities in administering the benefits on a decentralized basis.

10. **Allocation of Funds**—The law should clearly state the policies to be observed in allocating the insurance funds to the states.

11. **Federal Administration**—Administration of the national aspects of the program should be assigned to a small board of full-time members that included both professional and nonprofessional members, constituted so as to coordinate this insurance system with other social security and public health programs. The law should also establish an advisory council, with members representing the interested public, consumer and professional groups, and with responsibility to advise the Federal board.

12. **Collections**—Administration of the insurance plan, if linked with the existing system of national old-age and survivors insurance, could take advantage of existing machinery for collection of contributions, etc.

PHASE TWO—TOOLING UP

The three-year wait between enactment of legislation and the effective date of insurance benefits is essential to the program. The "tooling-up" period would be employed: (1) To increase medical resources—doctors and hospitals, for example—and to encourage their better distribution, so as to provide the maximum services possible, beginning with the effective date; (2) to set up administrative operating machinery; and (3) to make certain insured persons and providers know their rights and are ready to exercise them.

PHASE THREE—OPERATIONS

Beginning with the effective date insured persons and their dependents would obtain the health and medical services they need up to the capacity of the personnel and facilities existing at that time and limits of local availability.

The number of persons covered in the United States by health insurance will depend on the terms of the basic legislation. If the law were enacted at once, and coverage made identical with that of the present old-age and survivors insurance system, benefits would be available to some 85,000,000 persons, counting insured workers and their dependents—a little more than 60 per cent of the population.

When old-age and survivors insurance is ex-

panded to cover groups not now included, a matching expansion of health insurance could cover between 120,000,000 and 130,000,000 people—nearly 90 per cent of the population.

The ultimate goal is that every person should be eligible for insurance benefits.

SERVICES OF PHYSICIANS

Health insurance should, from the beginning make the services of general practitioners of medicine generally available to all the insured. The plan should cover all the services which a legally qualified physician engaged in the general or family practice of medicine gives to his patients at his office, in the patient's home, at the hospital or clinic, or elsewhere. It should include preventive, diagnostic, and therapeutic treatment and care, periodic physical examinations, and the prescribing of necessary drugs and appliances.

In metropolitan areas, all important specialists' services—including surgical and obstetrical services—probably would be available at the outset. Arrangements would be made for specialists and consultants whenever necessary—for example, for obstetrics, pediatrics, major surgery, heart disease, cancer, and diseases of the eye, ear, nose and throat. In medium-sized and smaller towns and in rural areas, the insured would have access to some kinds of specialists close by, but would probably have to go to urban centers or depend on visiting experts for other highly specialized services.

SERVICES OF HOSPITALS

General hospital services would be available to most insured persons, though in the first years some local deficiencies probably will exist. Hospitals would continue to be owned and managed by their present governing bodies, with full autonomy.

There would have to be an extra charge if a private room were used, and since demand may exceed the capacity of hospitals until the building program is complete, some limitations on the number of days of care probably would be necessary.

Dental Care—The extreme shortage of dental personnel makes it difficult to estimate the degree of availability under insurance. In many communities it should be possible to provide preventive dental care at least for children, and minimum continuing care for adults.

Home Nursing—The availability of home-nursing care will be uneven among different areas and may have to be limited to serious cases until the number of nurses increases.

COST OF INSURANCE

For the basic services—physicians, hospitals, expensive prescribed medicines, and appliances

—the insurance contributions in the first years after the program goes into effect would need to be raised from the nominal rate of the tooling-up period to about three per cent of annual earnings up to \$4,800 a year, probably divided between subscriber and employer.

If the dental and home-nursing services start on a limited basis and develop gradually, it will be difficult to fix a contribution schedule that would not require several changes. The cost might amount to an additional 0.5 per cent of annual earnings at first and rise to about one per cent when these services become more adequate. The Federal government might consider paying for these services out of general revenue.

Such financing would be sufficient to pay for the services needed by the insured population at rates fair to the practitioners and the institutions furnishing the services.

These expenditures would represent new burdens on the economy or on the contributors only to a limited extent. They would be, for the most part, substitutes for expenditures already being made, without insurance, for the same kinds of services.

PHASE FOUR—EXPANSION

With the beginning of operations under Government insurance, the effect of increased demand for services would make itself felt. Total and per capita costs for the insurance system as a whole will increase as services expand, but even when comprehensive services are available to everyone in the country, the contribution rate should not rise more than an additional one per cent—to a total of four per cent. The Federal government might use general revenues to supplement the contributions, as necessary, in the amounts equivalent to a fixed maximum percentage of contributions.

One of the first effects would be an increase in the amount of recognized illness, an increase in the amount of service requested. This would be the stage when health insurance brings unrecognized, hidden, or neglected illness out into the open by making medical care more easily available.

After a few years of this, we should expect a leveling-off and eventually an actual decline in the amount of serious illness. The amount of service may continue on a high level, but the proportion of preventive services could be expected to increase.

FOURTH HEALTH GOAL

“To focus attention on mental health as a leading area for medical progress in the last half of this century; to promote research in the field of psychiatry and in the mental-emotional aspects of physical illness; to expand manpower

and facilities for both preventive and curative work throughout the country; to accomplish these objectives through use of Federal research and other Federal assistance."

Over half of all patients in hospitals on any given day—some 600,000—are mental patients. Every year, 150,000 are committed to mental hospitals. Some 2,000,000 men were either rejected or discharged by the armed services because of neuropsychiatric disorders.

From 30 to 50 per cent of all patients consulting doctors have complaints due at least in part to emotional disorders; 350,000 people each year are disabled from accidents; 60 per cent of these accidents stem partly from personality causes and nearly one-third of these have no other cause.

Of more than 600,000 hospital beds occupied by the mentally ill, only about 400,000 meet minimum standards; moreover, there is an immediate need for 307,000 more beds for mentally ill patients. Our mental hospitals are severely understaffed and underfinanced. We have 600 psychiatric clinics for preventive work, against an immediate need for 1,400. We have only a handful of child guidance clinics. We need one mental health clinic for every 100,000 population.

FIFTH HEALTH GOAL

"To enable everyone in the Nation to enjoy a healthy, active, and productive maturity, by controlling chronic diseases—the greatest single barrier to achievement of this goal—and by relieving the other physical, mental, and social problems of adult life."

Half of the population is now over 30 years old, whereas in 1800 the median age was 16 for the entire country. We now have 10,000,000 people over 65 years old; by 1975, their number will probably have doubled to 20,000,000. More than a third of the Nation by that time will be 45 years old or more.

This population trend will mean a further increase in chronic diseases unless we can make rapid progress toward bringing them under control. Older people are responsible for 70 per cent of all invalidism and partial disability. Of the total death toll of 1,402,000 in 1945, chronic diseases were responsible for 1,014,000. These deaths are divided as follows: Heart disease, 424,000; cancer 177,000; brain lesions 129,000; nephritis 83,000; tuberculosis 53,000; diabetes mellitus 35,000; and other chronic conditions 113,000.

SIXTH HEALTH GOAL

"To rehabilitate the 250,000 men and women who become disabled through illness or injury every year so that they can be restored to the

most nearly normal life and work of which they are individually capable."

Each year about 250,000 men and women are so disabled by injury or disease that they become incapable of holding a job or of enjoying a normal life. Relatively few of this number suffer impairments so severe that they must always lead sheltered lives.

SEVENTH HEALTH GOAL

"To assure to every child in the country the utmost degree of health, a condition in which all his physical and mental powers are functioning at their best; to do this through a national plan that will build progressively toward complete medical care and social, psychological and health services for all children and mothers in childbirth."

Each year 162,000 people under 20 die, although we have the knowledge and the skills to save the lives of nearly half of these.

EIGHTH HEALTH GOAL

"Planning and action in every community and every state, directed toward providing the best possible health conditions for all their people, by assuring adequate local supply of needed services, and by organizing the local agencies of health—doctors, hospitals, public health departments, voluntary groups—into effective teamwork for the welfare of the entire community."

NINTH HEALTH GOAL

"To establish everywhere local health units with full-time qualified staffs adequate to the needs of the population; to increase and improve the training of public health workers to the end that their numbers shall be doubled as rapidly as feasible."

Our national deficiencies in the field of local public health departments are extreme:

There are 40,000,000 people in some 1,200 counties either without a public health department or with departments that have only a part-time health officer.

There are 96,000,000 people in the rest of the country served by inadequately staffed public health departments.

Only 7,000,000 people in the entire country are served by public health staffs that fully meet the minimum standards laid down by experts in this field.

In 1946 approximately \$67,000,000 was spent for local health services throughout the Nation. Contributions were divided as follows: Communities 75 per cent; states 6 per cent; Federal government 18 per cent; and voluntary agencies 1 per cent.

"I recommend, therefore, that the present

system of Federal grants-in-aid through state health departments be expanded promptly, and that the Federal government appropriate \$250,000,000 for this purpose during the next five years. The appropriation should be increased promptly to \$40,000,000 annually and by 1953 should rise to \$58,000,000."

Plans For Continuing Work of Health Assembly Adopted

That the National Health Assembly, held in Washington last May, is not by any means a defunct organization—a "one-timer" as it were—is indicated by a review of the proceedings of a recent meeting of the Steering Committee of the Executive Committee of the Assembly. The purpose of the Steering Committee, of which Dr. George F. Lull, secretary, American Medical Association, is a member, is "to survey all possible programs for future action, and ways and means of financing and staffing such programs."

SPECIFIC RECOMMENDATIONS

Five specific recommendations of the National Health Assembly were disposed of as indicated in the following:

(1) That a National Commission on Chronic Disease be established around the nucleus of the existing Joint Committee on Chronic Disease (American Medical Association, American Hospital Association, American Public Health Association, American Public Welfare Association) to study the extent and effects of chronic illness and to set standards for the prevention and treatment of chronic illnesses. Dr. Lull expressed willingness of the American Medical Association to take over the responsibility of setting up such a commission. After discussion, the Steering Committee requested Dr. Lull to go ahead. It was agreed that consumer groups should definitely be included in the new commission when it is expanded from the present Joint Committee. The functions of the Commission would include study not only of the medical aspects but of the social implications of chronic disease and the aging process. The Steering Committee felt it desirable that the new commission also serve as a means of stimulating action on the various problems posed by chronic illness.

(2) That a careful study is needed to develop standards for care of the mentally ill in general hospitals, so as to guide state health and hospital authorities in fulfilling their responsibilities under the Hospital Construction Act. The Steering Committee decided that this recommendation could most appropriately be carried out by the Public Health Service of the Federal Security Agency.

(3) That the Federal Security Administrator call a national conference on school health services, to define the contributions which all partici-

pating groups can make, to help insure more systematic and widespread programs, and to promote the integration of school health efforts with the total community school health program. The Federal Security Administrator agreed that there was need for such a conference and will study the possibilities for convening one.

(4) That need exists for broadening the concept of rehabilitation from its present vocational focus to that of a broad program of aid and services to the handicapped—a complete reorientation from present practices and philosophy in the field of rehabilitation. Again, this seemed a recommendation which could most suitably be implemented by the Federal Security Agency. Representatives of the Agency assumed the responsibility for calling a meeting of all groups working in rehabilitation, with a view to securing increased integration, coordination, and cooperation among them. It was felt advisable that such a conference be held under the joint auspices of the Office of Vocational Rehabilitation and the Children's Bureau, both of whom are component units of the Federal Security Agency.

(5) That a commission be created to define standards for dental health care more explicitly than is now the case. Recent legislation has established a new Council on Dental Health. It was agreed that this recommendation should be turned over to the Council for implementation.

FUTURE OF ASSEMBLY

As to the future of the National Health Assembly the Committee recommended that the Assembly become an independent, voluntary group, cooperating with the Federal Security Agency, and other governmental and non-governmental organizations. It was agreed that the continuing organization would function under its present name, and that necessary exploration would be made to prevent duplication of the programs of existing organizations.

The Steering Committee prepared and unanimously approved the following statement setting forth the future activities of the National Health Assembly:

1. To make plans and stimulate activities to meet national, state, and community health needs.

2. To encourage local initiative, interest, support, and participation of the entire community in the furtherance of health through local and state health councils and other means.

3. To cooperate with governmental units and with nongovernmental organizations on national, state, and local levels.

4. To stimulate regional, state, and local health conferences, securing the broadest possible representation and support both of lay and professional groups.

5. To encourage local areas to examine their

health needs and problems and formulate their own programs for action.

6. To follow through on the recommendations made by the National Health Assembly in May, 1948, and to point the way whereby the broad recommendations may be made more specific.

7. To publish and disseminate material from the Assembly held in May, 1948.

8. To act as liaison with existing commissions; and to recommend new commission in special fields as needed.

9. To serve as central clearing house for information on health needs and activities.

10. To plan for future national health assemblies.

11. To explore ways and means of securing increased financial support for meetings, publications, and other activities necessary for carrying out the above functions.

Arthritis and Rheumatism Foundation Scientific Committee Formed

Appointment of ten nationally known physicians and scientists to the Medical and Scientific Committee of the recently organized Arthritis and Rheumatism Foundation has been announced by W. Paul Holbrook, M. D., Tucson, Ariz., president of the Foundation.

The committee will guide the medical policies and activities of the Foundation. Functions of the committee will include the development of programs which can be undertaken by the Foundation's 38 local chapters which are being organized throughout the country. It will establish and promote medical standards, particularly with regard to rheumatism clinics and goals for medical education in the field of rheumatism.

Members of the committee are: Dr. Guy A. Caldwell, New Orleans, professor of clinical orthopedics, Tulane University of Louisiana School of Medicine; Dr. Russell L. Cecil, New York, professor of clinical medicine, Cornell University Medical College; Dr. Robley D. Evans, Boston, professor of physics, Massachusetts Institute of Technology; Dr. Morris Fishbein, Chicago, editor, *The Journal of the American Medical Association*; Dr. Philip S. Hench, Rochester, Minnesota, professor of medicine (Mayo Foundation), University of Minnesota Medical School; Dr. Andrew C. Ivy, Chicago, vice-president in charge of the Chicago Professional Colleges, University of Illinois; Dr. Karl F. Meyer, San Francisco, director, the Hooper Foundation, University of California; Dr. Currier McEwen, dean, New York University College of Medicine, New York; Dr. Walter W. Palmer, New York, director, William Hallock Park Laboratories, Public Health Research Institute of the City of New York, Inc.; and Dr. Howard A. Rusk, New York, professor of rehabilitation, New York University College of Medicine.

Reservations Now in Order for A. M. A. Interim Session

Registrations and hotel reservations are now being accepted for the second annual Interim Meeting of the American Medical Association at St. Louis from Tuesday, November 30, to noon, Friday, December 3.

On the eve of the Interim Meeting, Saturday, November 27, the first national Medical Public Relations Conference will be held under sponsorship of the A.M.A. at the Statler Hotel.

Planned to be especially valuable to the general practitioner, the Interim Session will offer lecture meetings, conducted by medical leaders, on conditions most often seen in daily practice. Subjects to be discussed include diabetes, heart disease, cancer, poliomyelitis, obstetrics, pediatrics, dermatology, genito-urinary conditions, hypertension, anesthesia, tuberculosis, jaundice, laboratory diagnosis, X-ray diagnosis, and physical medicine as applied to the treatment of arthritis.

Diagnosis and treatment will be stressed in a wide variety of clinical conferences, which will be correlated with the lecture meetings. Leading practitioners from all sections of the nation will conduct these conferences.

Evening programs will feature distinguished speakers, the award of the general practitioner medal, and fun.

A scientific exhibit will feature nearly 100 displays. Leading firms will display technical exhibits. All exhibits will be open from Tuesday at 8:30 a. m. to Friday noon, November 30 to December 3.

Papers will be read at the General Scientific Meetings in the St. Louis Opera House from 9 to 10 a. m. and from 2 to 3 p. m. each day.

A registration form which enables the physician to save time by securing a registration card in advance, is appearing in *The Journal of the American Medical Association* every other week until the Interim Meeting.

All reservations must be cleared through the Chairman, Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, 1420 Syndicate Trust Building, St. Louis 1, Mo., and must be received before November 9, 1948.

To Meet In Los Angeles

Surgeons from thirty-two states and from two Canadian provinces, with one speaker from Stockholm, Sweden, are listed as participants on the program announced by Dr. Irvin Abell of Louisville, Chairman of the Board of Regents of the American College of Surgeons, for the thirty-fourth Clinical Congress which will be held in Los Angeles, with headquarters at the Biltmore Hotel, from October 18 to 22.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

BETWEEN NOW AND TUESDAY NOVEMBER 2

It is assumed that every Ohio physician knows that Tuesday, November 2, will be a mighty important occasion. This year's general election on that day carries added significance to members of the medical profession because of the emphasis being placed on health and medical question by the political campaign orators.

It is assumed that all Ohio physicians and the voting members of their families will go to the polls on Tuesday, November 2, and will vote for candidates who are qualified for public office and whose views on medical and health matters are sound.

But, what about the period between now and November 2? That's the crucial time. That's when spade work for candidates is done. That's when folks are advised about the good and bad candidates. That's when you find out about candidates, not on election day morning.

So, Ohio physicians should get busy right now. First, get advice from the officers and legislative chairman of your county medical society. Most of the candidates have been interviewed by officials or committeemen of the county medical societies. That information is available to members—if it isn't, it should be. Secondly, after getting the facts, get busy electioneering for those who measure up. Thirdly, see that the right information is circulated among patients, neighbors, and acquaintances. Fourthly, prepare to vote and get lots of other folks to do so. Fifthly, do a real job in trying to elect the right man for the Presidency and Governorship but don't forget it's mighty important who is elected to the Congress and the Ohio General Assembly where laws are made and the chief executive is checkmated if he starts to get off the reservation.

There's a job for doctors to do between now and November 2. It's time for them to get busy—and how!

NEW BOOKLET ON HOSPITAL DESIGNING AND CONSTRUCTION

The American Institute of Architects' Department of Education and Research, 1741 New York Avenue, N. W., Washington 6, D. C., has just published a booklet, entitled "The Hospital Building," which should be of great value to physicians and others who may be interested in the construction of a new hospital or the remodeling of a present one. It may be purchased for \$2.00.

The material presented covers such subjects as administrative aspects of hospital design, programming for hospital design, development

of hospital plans, hospital room details, hospital construction, details, finishes, and equipment. Also included is an extensive bibliography of reference material on almost every conceivable subject relating to hospital management, planning and construction.

Many physicians are taking a direct interest in programs to expand hospital beds. They might find this publication of real help.

MORE ABOUT THE RAKESTRAWS AND THEIR OUTFITS

An article regarding Mary and George Rakestraw and the League for Cross Eye Correction appeared in the August issue of *The Journal*. It indicated that Ohio has the Rakestraws and their dubious organization on the run. Read it if you haven't done so as it presented some interesting sidelights on an outfit which has been fooling a good many people in Ohio for far too long, including some local units of one well-known luncheon club which would have known better had it merely inquired before investing.

But, the Rakestraws, especially George, are persistent folks. During the early part of September, a number of newspapers in Northeastern and Northwestern Ohio carried advertising of the Cross Eye Foundation, Pontiac, Michigan, requesting folks to write in for a free booklet on the "one-day" treatment and full particulars—where to get it, of course. That's Mary Rakestraw's outfit.

About the same time, other newspapers carried advertising of the National Cross Eye Institute, Flint, Michigan. Those ads stated representatives would be at such-and-such hotel on a certain day and urged folks to come in for an interview, free advice, etc. That's George's outfit. It seems Mary and George have split up as man and wife and in their business relationships also.

An inspector for the State Medical Board walked in on George in Fostoria and had a long

chat with him. Since George had no customers, he couldn't be arrested for practicing medicine unlawfully. But, George was warned that he had better get for home and stay out of Ohio or he would find himself in the jug. He had left town within an hour after the conference. George had been over in Pennsylvania selling his wares and stopped off in a few Ohio towns while passing through.

The State Medical Board and the office of the Attorney General are keeping a close eye on both the Rakestraws. If they, or any of their representatives, bob up in Ohio again, they will be arrested if it is at all possible to file charges against them.

Also, there are a few folks who have under consideration the possibility of filing charges against both organizations and their principals for misuse of the mails.

Here is how Ohio physicians can help in keeping the Rakestraws and their cohorts out of Ohio:

Advise the State Medical Board or State Medical Association by telephone if an advertisement appears in a local newspaper announcing the holding of one of the so-called hotel conferences or clinics. If this is done in time, an inspector will visit their little party.

Advise hotel managements about the organizations.

Advise local newspaper managements about the organizations, referring to this article and the one published in the August issue.

Advise local civic clubs of the organizations—a warning as it were.

Warn patients who may inquire about this so-called treatment.

MISCONCEPTION ABOUT MEDICAL SCHOOL ADMISSIONS

There seems to be a widespread misconception of the power of the medical profession or certain official organizations within the profession in limiting the number of students in medical schools. Judging from their comments, a few educators, who should know better, have a misconception of the real situation.

Actually, there is no such thing as a direct quota system imposed on any medical school by any accrediting agency. The only influence is indirect through setting of standards. Certainly no thinking person would want standards lowered to a point where medical schools could deliver quantity but not quality. In fact, a medical school retains full power to train as many physicians as it pleases. Nevertheless, it should be certain that it has the resources and facilities to deliver both quantity and quality.

In the final analysis, the solution to the problem of supplying a greater number of physicians

—admittedly a problem—rests with the taxpayers and philanthropic organizations. If they are willing to furnish the money for sound expansion of medical schools or the organization of new ones, the problem can be solved. This is the most practical way for people who want more doctors to get them; also the safest way.

LOCAL FINANCING OF HEALTH UNITS

In August, *The Journal* published an article regarding a bulletin sent to all local health commissioners by Dr. John D. Porterfield, state director of health, in which Dr. Porterfield discussed the current picture of public health financing in Ohio, outlining particularly the problems of the state department. That bulletin contained a lot of food for thought. We hope that many physicians read it and then decided to help correct the problems which are so obvious.

Another bulletin has been issued by Dr. Porterfield in which he discussed the question of financial support of local health units, local appropriations, budgeting, etc. This, too, is a bulletin which deserves the close attention of the medical profession. In fact, it not only contains some sound advice for local health commissioners and local boards of health but it also is a challenge to the medical profession and the public generally to get behind their local health department in its quest for adequate funds. Obviously, the local health department must offer a real program. If this is done, then the community must exert sufficient pressure to see that the official appropriating bodies deal fairly and squarely with the department. That's where the medical profession can join with other citizens in doing a real job, namely make sure that adequate funds are supplied. The local commissioner should take the public and the medical profession into his confidence on this matter, so that they can back up his requests and recommendations to the budget commission or to the city council.

Several pertinent excerpts from the bulletin, indicating sound and diplomatic procedures in budgeting and planning, are as follows:

"All too often the submission of a budget to an appropriating body is looked upon by the administrator as one of the crosses he must bear instead of an opportunity to establish a definite work plan for his department; with justification, priority of objectives, and establishment of goals for the year's work. The poorest justification for a budget that might possibly be conceived is that which is so often used—'the amount of money spent last year.'"

"Sound budgeting demands planning. It requires the administrator and staff to: first, define clearly what it is they wish to accomplish; secondly, what steps shall be taken in order to accomplish those purposes. These are then translated into a work program in terms of personnel,

salaries, and travel, housing requirements, capital expenditures, and contingent operating costs. The administrator should be able to justify items specifically and not in vague generalities. Such questions as these should be answered:

- "1. Is the program worth while and is it needed in this jurisdiction?
- "2. Do past accomplishments justify continuance?
- "3. Are forecasts of demand for service dependable?
- "4. Is the organization and distribution of work practical?
- "5. Has duplication of work been avoided??
- "6. Is the proposed plan the most efficient and economical way to do the job?
- "7. Is number of personnel consistent with work to be done?

"Planning is continuous and must be dynamic. Last year's plans become inadequate and must be modified to meet changing circumstances. Preparation of the annual budget is an unparalleled opportunity for the health department to take stock of its present situation and make definitive plans for its program in the ensuing fiscal period."

THE COMMUNITY CHEST AND YOU

If somebody suddenly asked you "What is the Community Chest?" you'd probably say, "Well, it's a group of organizations that help people."

And you'd be right.

But nine chances out of ten you'd be thinking that the people it helps are the "other people"—not by any chance you.

And you'd be wrong.

For one thing, you, as a physician, and your family benefit just as much as the other

munity Chest is a wholesome and democratic force in any man's town.

If you believe in order. The Community Chest is the orderly way to plan and raise money for voluntary services. Instead of turning loose on the town 50 separate appeals, it unites most of them into one campaign, with one big goal to meet many big needs.

If you believe in fairness. The Community Chest allocates the money raised fairly among its member agencies instead of making them compete with each other for public interest and support.

If you believe in economy. The Community Chest conserves leadership, time and money, cuts administrative costs and thus delivers the maximum value of each dollar raised to the purpose for which it was given.

If you believe in American enterprise. Our government can do a lot for our welfare, but it can't build us good communities to live in—that's up to us citizens. In its support of voluntary non-governmental services the Community Chest puts its faith in a good old American ideal: the good community is built not by compulsion but by cooperation; not by selfishness but by sharing.

Assuming that you agree with all this: Get ready to do your part in the Community Fund campaign of your city. You can help in two ways: First, by making a financial contribution in keeping with your means; (2) by joining those who participate in the campaign activities. It takes manpower to put on a good fund raising program.

HOW YOU CAN HELP TO SOLVE THE NURSING PROBLEM

Some of the things which physicians can do to assist in the recruitment of student nurses, one of the all-out attacks being made on the problem created by the shortage of nurses, are as follows, according to the officials of the recruitment program, sponsored by many national organizations:

1. Offer to speak on the opportunities and advantages of professional nursing at special local recruitment programs.
2. Permit displays (posters, special literature, etc.) to be set up in the waiting rooms of their offices.
3. Point up the advantages of professional nursing among patients, particularly those who have young daughters.
4. Discuss the opportunities and advantages of nursing among civic groups in which they hold membership.
5. Inform recruitment chairmen about all prospective candidates they might learn of through conversation with patients, friends, etc.

The nursing situation is as acute in Ohio as elsewhere. Therefore, it is hoped Ohio physicians will put the above suggestions to work.



fellow's family by the presence in your town of health education agencies, groups to help the needy, recreational centers, summer camps, Y.M.'s and Y.W.'s, Scouts—to name only a few familiar Red Feather services.

Even if you or your children never should use one of these services, you still benefit by the Community Chest. And this is how:

If you believe in your community. The Com-

Rural Health Activities . . .

Fair Exhibits, Radio Broadcasts, 4-H Club Health Contest, Help Promote Association's Rural Health Program Throughout State

A FAR-REACHING project in the rural health program of the Ohio State Medical Association was the booth at the Ohio State Fair of which the theme was protection of farm families against brucellosis.

The booth occupied a strategic position in one corner of the Ohio Building, one of the most popular buildings at the fair through which well over a hundred thousand persons passed during the period August 28-September 3.

The exhibit was one step in an extensive program launched by the Association's Committee on Rural Health to warn farm families about the dangers of brucellosis. The committee is headed by Dr. Carll S. Mundy of Toledo.

Personnel who manned the booth were members of the Headquarters Office staff and senior medical students from Ohio State University College of Medicine, who answered questions prompted by features of the exhibit and by the pamphlet on brucellosis, copies of which were passed out. The students were David Parke, William Donovan, Wesley Pignolet and Kirkwood Pritchard.

The pamphlet, "Mr. Farmer, Protect Your Family From the Advancing Menace," is being distributed extensively throughout the State. Requests quickly exhausted the first printing of 50,000 copies. About half of a second printing of 50,000 copies have been distributed. Requests are still coming in heavily from agricultural agents, health commissioners, farm organizations, rural physicians, and others.

A companion exhibit emphasizing control of brucellosis by eradication of the disease in livestock was sponsored by the Division of Animal Industry of the State Department of Agriculture. A folder on this subject has been published and is being distributed by the Ohio State Veterinary Medical Association.

The exhibit also was shown at the Jackson Apple Festival, September 22-25 under the co-sponsorship of the Ohio State Medical Association and the Jackson County Medical Society, and at the Highland County Fair, Hillsboro, September 21-24, under co-sponsorship of the Highland County Rural Health Council. It will be featured also at the Circleville Pumpkin Show,

October 20-23, with the Woman's Auxiliary of the Pickaway County Medical Society as co-sponsor.

4-H CLUB CONTEST

Another opportunity in the promotion of rural health was furnished the Association when Dr. J. Martin Byers, Greenfield, a member of the Committee on Rural Health, was appointed one of the judges of the Ohio 4-H Club Health contest which was held during the State Fair. Other judges were Sewall Milliken, specialist in rural health for the Ohio State University Agricultural Extension Service, and Miss Beatrice Smith, Holmes County home demonstration agent.

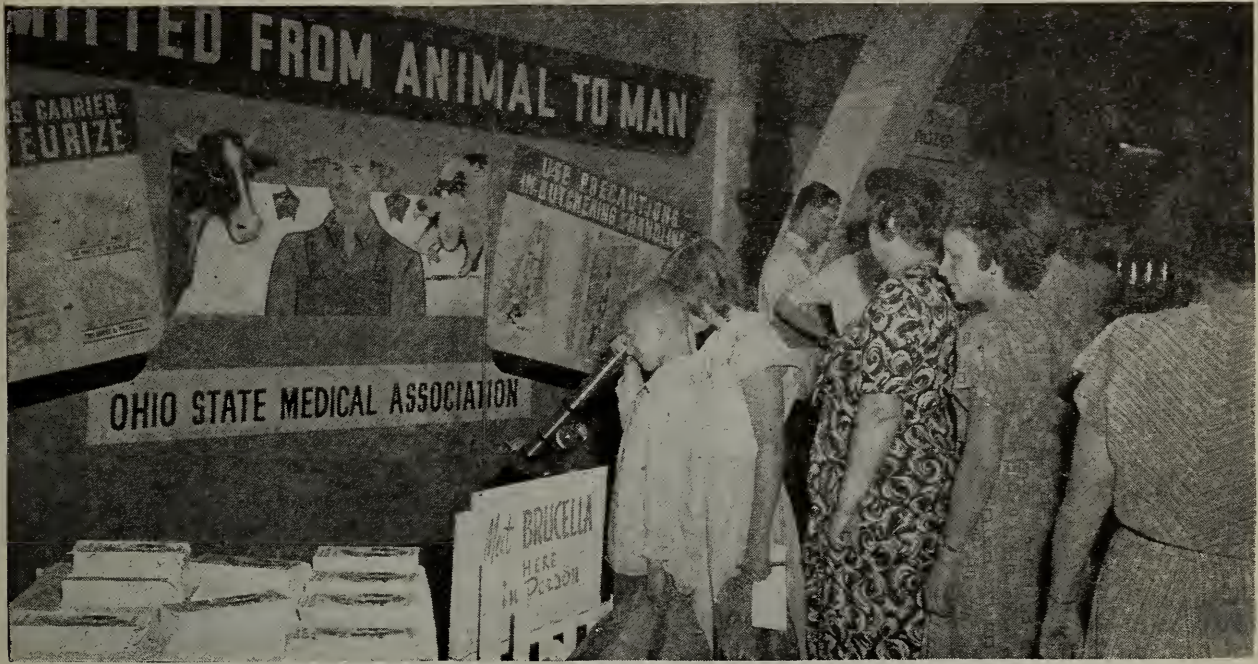
The contest was the year's climax of graduated scale of contests through which health was promoted among Ohio 4-H Club members. The annual contest is initiated within local clubs, and is based on the individual's promotion and maintenance of his own health, and the promotion of health and sanitation in the home, on the farm and in the community. The winning girl and boy in each club takes part in a county contest, and the winners of the county contest advance to the State contest.

Dr. Byers and other judges spent three days with contestants, judging their check sheets, narratives, receiving their personal responses to the health program, and giving actual physical examinations. A great deal of emphasis in the contest was placed on periodic examinations by family physicians and immunizations. In place of the former policy of picking the healthiest youngsters in the state, the contest was based more on the contestants' promotion of health. Winners were Rita Louise Hewitt, of Defiance, and Milo Billman, R. F. D., Wadsworth. They will go to the National 4-H Club Congress in Chicago, November 28-December 3, to take part in the national contest.

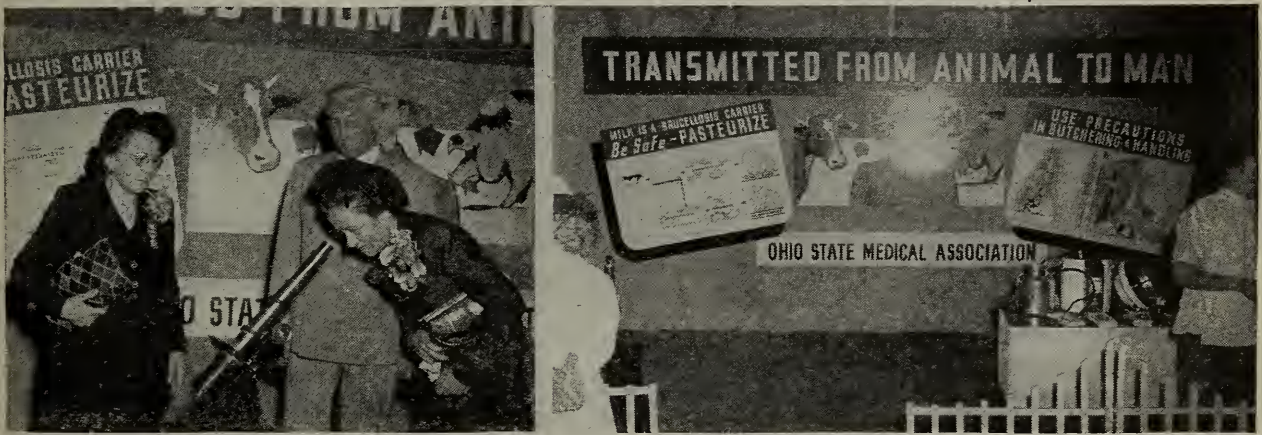
PROGRAM ON THE AIR

Activities of the brucellosis program have been extensively aired by radio. A wire recording broadcast was made at the Association's booth at the State Fair by George Zeis of Radio Station WOSU. Hart F. Page, secretary for the Committee on Rural Health, and Harry G. Geyer,

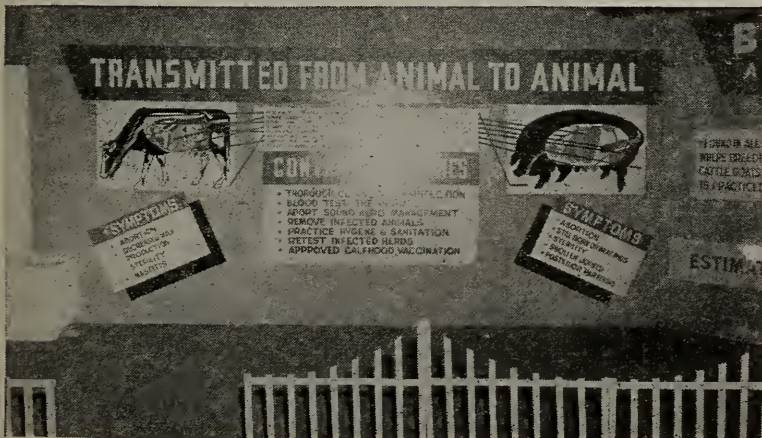
Association Promotes Anti-Brucellosis Program At State Fair



Popular appeal of the Association's exhibit was indicated by the fact that nearly 12,000 brucellosis pamphlets were carried away by interested persons. O.S.M.A. Staff Photos

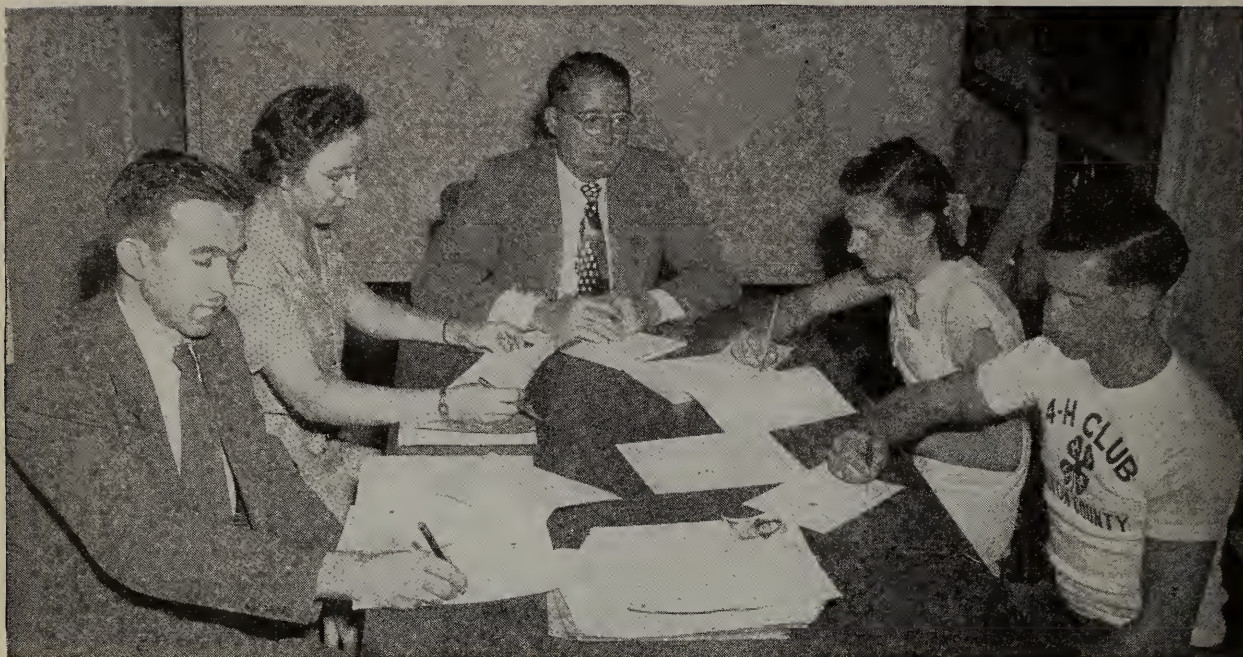


(Left) Governor and Mrs. Thomas H. Herbert take turns viewing brucellosis bacteria, while Mrs. Lottie Randolph, assistant state director of agriculture, looks on. (Right) Dramatic panels emphasize safety precautions on the farm.



(Left) A companion exhibit was promoted by the Division of Animal Industry of the State Department of Agriculture and the Ohio State Veterinary Medical Association. (Right) 4-H Clubbers Marilyn Smith and Luella Staley of Union County put on a home pasteurization demonstration at Association's booth.

4-H Club Health Contest Judges in Action



Dr. Byers, center, representing the Ohio State Medical Association, helped to judge the 4-H Club health promotion contest. Other judges were Mr. Milliken, left, and Miss Smith. At right are two contestants, Marjorie L. Baker, Richland, and Dick Shaddle of Fulton County. O.S.M.A. Staff Photo

State Veterinarian, were interviewed during the recording

Dr. A. D. Harvey, Lebanon, member of the Committee on Rural Health, and Mr. Page promoted the brucellosis program further on September 4 when they took parts on WLW's popular rural program, "Everybody's Farm Hour." They were interviewed by Roy Battles and Betty Brady of the WLW staff.

Radio Station WOSU, the Ohio State University station, carried a broadcast concerning the campaign on September 3 during the "Farm and Home Hour."

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since Aug. 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

CUYAHOGA COUNTY

Allen E. Walker,
Bay Village

GEAUGA COUNTY

Gene D. Chirelli, Parkman

HARRISON COUNTY

Donn Tippet, Cadiz

LUCAS COUNTY

W. G. Henry, Toledo
John R. Phillips, Toledo
Phillip C. Stiff, Toledo
James B. Tobias, Toledo

MAHONING COUNTY

A. J. Bayuk, Youngstown
Clyde K. Walter, Canfield

MONTGOMERY COUNTY

Alfons R. Altenberg, Dayton
Irwin H. Altenburg, Dayton
Lee R. Ashmun, Dayton
Joseph M. Klausner, Dayton
Wm. M. Leavenworth, Dayton
Irvin L. Libecap, Dayton
J. C. Lunderman, Dayton
George W. Markus, Dayton
Herbert R. Moore, Dayton

Health Commissioners to Meet

The 29th Annual Conference of Local Health Commissioner will be held in Columbus on Thursday and Friday, October 21 and 22, at the Deshler-Wallick Hotel, beginning at 9 a. m., Dr. John D. Porterfield, director of health, announced.

In collaboration with the officers of the Ohio Federation of Public Health Officials, a voluntary organization, the Ohio Department of Health has established committees composed of local health commissioners who will be asked to consider specific portions of the state public health program.

The form of the conference will be changed to make it more of an executive session wherein state program chiefs and local health commissioners may discuss state-local relations in public health, Dr. Porterfield said. Although the conference is primarily for health commissioners, other local health personnel are invited.

Urology Award

The American Urological Association is offering an annual award of \$1000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals. For particulars write Dr. Thomas D. Moore, 899 Madison Ave., Memphis 3, Tenn.

Hospital Services . . .

Annual Report of A. M. A. Council Reveals Interesting Data on Facilities and Demands of Registered Institutions of Nation

THE shortage of hospital beds throughout the nation continued to remain acute during 1947 with the following trends being evident: The number of beds decreased; the number of admissions increased, but was offset by a decrease in the average hospital stay per patient; the number of births in hospitals reached an unprecedented high. These facts are revealed in the twenty-seventh annual presentation of hospital data by the Council on Medical Education and Hospitals of the American Medical Association as reported in the August 14 issue of the *Journal of the A. M. A.*, a summary of which follows.

NUMBER OF HOSPITALS

The number of registered hospitals, as compared with the previous year's report, remained about constant, with 6,280 registered in 1946 and 6,276 in 1947. There was a decrease of 45 hospitals in the governmental group, largely due to the continued drop in the number of Federal hospitals reported. This loss was offset by a gain of 41 hospitals in the nongovernmental groups, representing increases in the nonprofit association hospitals and those controlled by corporations (profit unrestricted).

Hospitals of 100-bed capacity and under showed a slight increase, as did those of from 101 to 300 beds, while larger hospitals showed a substantial decrease in number. Neuropsychiatric hospitals increased from 575 to 585, while tuberculosis sanatoriums decreased by about the same number from 450 in 1946 to 441 in 1947. General hospitals showed a gain of 18 over the previous report, perhaps fewer than would be anticipated.

BEDS DECREASE

From the high point of 1,738,344 beds reported in 1945, the bed capacity in registered hospitals has declined to its present level of 1,425,222 beds, representing a further decline of 52,529 beds in the governmental group, primarily Federal hospitals, and an increase of 9,037 in the nongovernmental category. This compares with a loss of 273,984 beds in governmental hospitals reported last year, and a gain in nongovernmental hospitals of 3,754 beds for the same period.

On the basis of currently available statistics, governmental hospitals (those operated by cities, counties, etc.) now control 72.3 per cent of all hospital beds and the nongovernmental group 27.7 per cent. This compares with 73.7 and 26.3 in 1946 and 78 per cent and 22 per cent in 1945.

It should be noted that 626,648 of the 1,030,205 beds under governmental control are located in state hospitals, largely of special types.

The bed capacity of general hospitals continued to decline, with 641,331 beds reported in 1946 and 592,453 the past year. This decrease, however, should be interpreted in the light of the increase of beds in the nongovernmental group. These latter rose from the figure of 324,211 for 1946 to 334,569 in 1947. General hospitals now represent 41.6 per cent of all beds, neuropsychiatric hospitals 47.9 per cent, tuberculosis sanatoriums 5.8 per cent, and other institutions 4.7 per cent. There was an appreciable gain in the number of neuropsychiatric beds from 674,930 to 680,913 during the period. This amounts to only about one-third the gain shown in these hospitals during the 1945-1946 period.

OHIO HOSPITALS

A breakdown of hospital facilities in Ohio is as follows:

Federal hospitals 7; beds 4,903; bassinets 1; patients admitted 20,018; average census 4,322.

State hospitals 26; beds 32,650; bassinets 36; patients admitted 26,633; average census 28,980.

County hospitals 27; beds 3,810; bassinets 100; patients admitted 20,740; average census 3,196.

City hospitals 19; beds 3,296; bassinets 398; patients admitted 71,743; average census 2,570.

Total governmental hospitals (a summary of the preceding) 79; beds 44,659; bassinets 535; patients admitted 139,134; average census 39,068.

Church related (nonprofit) 46; beds 8,067; bassinets 1,470; patients admitted 278,172; average census 7,185.

Nonprofit Associations 96; beds 9,873; bassinets 1,843; patients admitted 333,612; average census 8,129.

Total nonprofit 142; beds 17,940; bassinets 3,313; patients admitted 611,784; average census 15,314.

ADMISSIONS UP

The trend toward increased use of hospital facilities is seen in the greater number of admissions to registered hospitals reported in 1947. Notwithstanding an appreciable drop in the bed capacity, 4.4 per cent more patients were admitted than during the 1946 period. If nongovernmental hospitals alone are considered, the increase is over 10 per cent.

Of every 1,000 patients entering hospitals during the current reporting period, 926 were

admitted to general hospitals, 18 entered neuropsychiatric institutions, 14 were admitted to related institutions including convalescent homes, 10 to isolation units, 7 to eye, ear, nose and throat, 6 to tuberculosis sanatoriums, 6 to maternity hospitals, 6 to children's, 4 to industrial, and 3 to orthopedic hospitals.

Following the decrease in bed capacity (23,492), the average daily census for 1947 fell off by 22,225 patients, from 1,239,454 in 1946 to 1,217,229 for 1947. The percentage of beds occupied increased slightly from 84.4 per cent in 1946 and 85.14 per cent in 1947.

The length of stay per patient in all general hospitals was reduced by 1.5 days from the 1946 average of 12.9 days to the 1947 average of 11.4 days.

BIRTHS AT ALL-TIME HIGH

A striking increase in the number of births in registered hospitals occurred during the 1947 reporting period. Hospitals during 1947 reported a total of 2,837,139 births, a record figure, representing an increase of 32.8 per cent over the previous record year 1946. The following figures show number of births in hospitals for four comparative years: 1929, 621,896; 1945, 1,969,667; 1946, 2,136,373; and 1947, 2,837,139.

In Ohio during 1947 there were 170,594 births in hospitals.

GRADUATE NURSES, INCREASE

In 1941 there were 93,977 student nurses enrolled in accredited schools of nursing; a gradual yearly increase brought this figure to a peak total of 130,909 in 1945. In 1946 there was a decrease in the enrollment and again in 1947 a further drop to 94,133 students. There was also a slight drop in the number of accredited schools of nursing from 1,229 to 1,212 during the past year.

On the other hand, the number of graduate nurses in hospital positions has continued to rise, with 167,354 reported in 1947, an increase of 20,752 over 1946. The classification "general duty nurses, full time" accounts for 14,871 of this increase.

It was to be expected that the number of volunteer nurses' aides should continue to decrease with 3,116 fewer, or 9,688, reported in 1947. It is interesting to note that hospitals are making more and more use of those persons falling into the general classification of practical nurses and attendants, the figure for this group being 119,746 or 23,654 greater than in 1946.

Blue Shield plans have accumulated \$20,881,546 in assets during the past few years, of which \$9,947,547 are held in reserve accounts for contingencies of various kinds.

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Authorization was granted at the meeting of the House of Delegates of the North Dakota State Medical Association on May 23 for the expansion of Blue Shield to a state-wide program.

Established two years ago as an experiment in the Fargo area, Blue Shield has enrolled approximately 9,000 members and received the unanimous support of physicians in Cass County.

Distinguishing feature of Blue Shield in North Dakota is the provision of full service benefits to the subscriber and his dependents. Physicians in Cass County have been accepting the plan's fee schedule as full payment for services rendered, regardless of the patient's income status.

Concluding that the experiment had proved successful, the House of Delegates instructed its Committee on Medical Economics and a subcommittee on prepayment medical care to make the necessary arrangements for extending the plan throughout the state, such arrangements subject to final approval by the society's Council.

Blue Shield in North Dakota has been administered as a companion plan to Blue Cross during the past two years.

* * *

Blue Shield plans recorded a total income of \$48,445,245 during 1947, according to a financial report released recently from their national office in Chicago.

Payments to physicians totalled \$37,942,749, amounting to 78.14 per cent of the annual income; \$7,461,570 was expended for operating expense during the year, accounting for 15.37 per cent of the total income. The balance of \$3,154,186, or 6.49 per cent, was added to reserve accounts.

* * *

Doctors have often heard the charge that the voluntary prepayment medical care plans are dominated by the medical profession—that the public is not represented.

A recent review of reports from some 67 plans shows: 50 plans have joint representation on governing boards; 12 plans have doctors only; 1 plan has a non-medical board; and 4 plans could not be classified.

* * *

A preliminary study of 49 prepayment plans (those in operation a full year or more, including insurance company plans where breakdown permitted) the aggregate experience developed: \$0.779 spent for claims and medical services; .139 paid out for administration; .071 set aside for reserves; .011 paid out for miscellaneous items.

Do You Know? . . .

The first Governor of Ohio was a physician, Dr. Edward Tiffin, who began the practice of medicine in Chillicothe in 1798. He was elected Governor in 1803. Dr. Tiffin held various other public offices over a period of 31 years, including clerk of the common pleas court of Ross County; member of the United States Senate; member of the Ohio General Assembly; commissioner of what is now the Department of the Interior and surveyor-general of the Northwest. He died in 1820 at the age of 64.

* * *

John R. Mannix, former assistant director of the University Hospitals, Cleveland, former director of the Blue Cross programs in Michigan and Chicago, and more recently associated with the John Marshall Insurance Co., has been appointed director of the Cleveland Hospital Service Association (Blue Cross), Cleveland, succeeding John McNamara, resigned.

* * *

The Columbus Academy of Medicine is sponsor of the American Medical Association's transcribed radio program "Everyday Health Problems," over radio station WBNS, Columbus. The program began Saturday afternoon, August 7, at 2:45 p. m., and will continue for 13 weeks.

* * *

Dr. Frederick C. Swing, Cincinnati, has been appointed a member of the Ohio Conservation and Natural Resources Commission. He is a past-president of the Southern Ohio Dog and Game Protective Association, and a director of the Isaac Walton League.

* * *

Dr. Frank C. Sutton, medical director of the Rochester (N. Y.) General Hospital, has been named director of Miami Valley Hospital, Dayton.

* * *

The West Virginia State Medical Association has launched a campaign for a four-year medical school in that state.

* * *

Dr. Luther E. Cupp, Arcanum, is the new second vice-commander of the Ohio Department of the American Legion.

* * *

Ohio has been allocated \$166,500 for mental health activities from funds appropriated by the Congress under the National Mental Health Act.

* * *

The Montgomery County Medical Society sponsored an educational exhibit entitled "Know Your Heart," at the Montgomery County Fair, Sept. 6-9, at Dayton.

According to the National Tuberculosis Association, the tuberculosis death rate in the United States reached a new low of 33.2 per 100,000 population in 1947. The comparable rate for Ohio was 30.41.

* * *

An analysis of 100,000 surgical benefit claims of all ages made by the Actuarial Society of America showed that boys incur 15 per cent more surgical operations than girls, with 60 per cent of all children's operations being tonsillectomies and 20 per cent appendectomies or fractures.

* * *

A Health Emergency Planning unit recently established by the United States Public Health Service is headed by Dr. Norman C. Kiefer, senior surgeon. Before joining the U.S.P.H.S. staff a few years ago, Dr. Kiefer practiced in Geneva, Ohio.

* * *

Health legislation in the 80th Congress was reviewed by George H. Saville, Director of Public Relations of the Ohio State Medical Association, at a meeting of the local chapters of Child Conservation League in Washington C. H., September 1. The meeting was arranged by Mrs. W. H. Roszmann, chairman of the Public Relations Committee of the Woman's Auxiliary to the Fayette County Medical Society.

* * *

Officers of the American College of Allergists for 1948-1949 include: Dr. George E. Rockwell, Milford, president, and Dr. Jonathan Forman, Columbus, president-elect.

* * *

An instructor in the Department of Pathology of the Ohio State University College of Medicine and former coroner of Franklin County, Dr. Mitchell A. Spyker, Columbus, has been awarded a Rockefeller Foundation fellowship in the department of legal medicine at Harvard University.

* * *

Dr. F. William Sunderman, professor of clinical pathology and director of the laboratory of clinical medicine at Temple University, Philadelphia, has been named head of the department of clinical pathology at the Cleveland Clinic.

* * *

Dr. H. M. Platter, secretary of the Ohio Medical Examining Board, has been named to represent the medical profession on the five-member Ohio Draft Appeal Board. The board will be the only one of its kind in the State.

Postgraduate Seminar Speakers . . .

All Practical Phases of Chest Diseases, Diseases of the Heart and Dermatology Will Be Discussed at Association-Sponsored Programs

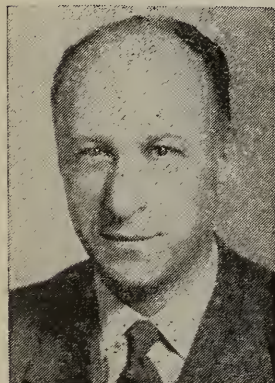
OHIO physicians will have an opportunity to hear discussions by 13 outstanding authorities in their respective fields, during the three postgraduate seminars offered by the Ohio State Medical Association in October and November. Detailed program of these courses appeared in the September issue of *The Journal* and similar programs have been mailed to members.



CARL A. WILZBACH, M. D.



JOHN H. SKAVLEM, M. D.



S. E. WOLPAW, M. D.

The courses are:

"New Advances in the Diagnosis and Treatment of Chest Diseases," Elks Home, 42 W. Second St., Chillicothe, Thursday, October 21, beginning at 2 p. m., (Eastern standard time).

"Practical Cardiology," American Legion Hall, North and West Streets, Lima, Wednesday, October 27, beginning at 2 p. m. (E. S. T.)

"Practical Dermatology," Mansfield-Leland, Hotel, Mansfield, Wednesday, November 3, beginning at 1:30 p. m. (E. S. T.).

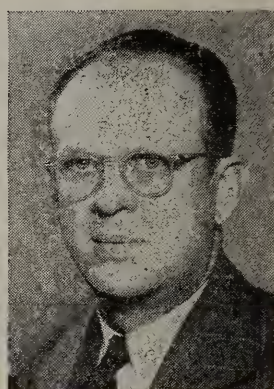
Included on these programs are:

Dr. John H. Skavlem, Cincinnati, associate professor of medicine, University of Cincinnati College of Medicine and medical director of the Hamilton County Tuberculosis Sanatorium. He will speak on "Pathogenesis and Clinical Considerations of Chest Diseases," at 2 p. m. during the Chillicothe meeting.

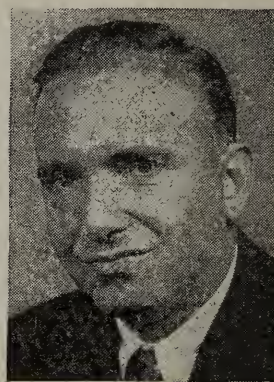
Dr. W. L. Potts, Columbus, superintendent and medical director of the Franklin County Tuberculosis Hospital, tuberculosis controller for Columbus and Franklin County, and assistant professor of medicine, Ohio State University College of Medicine. Dr. Potts will discuss "Laboratory Aids in the Diagnosis of Pulmonary Diseases," at 2:30 p. m. at the Chillicothe course.

Dr. D. W. Heusinkveld, Cincinnati, instructor in medicine, Division of Tuberculosis, University of Cincinnati College of Medicine and staff member of Dunham, Good Samaritan and Bethesda hospitals. He will speak on "Chest Films," at 3:15 p. m. at the Chillicothe meeting.

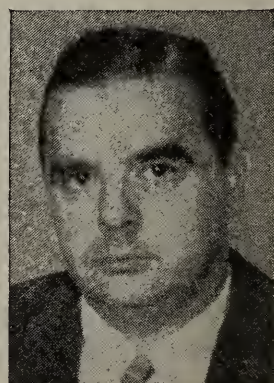
Dr. Joseph B. Stocklen, Cleveland, assistant clinical professor of medicine and preventive medicine, Western Reserve University School of Medicine, visiting physician for Sunny Acres Hospital and Lowman Pavilion City Hospital, and controller of tuberculosis for Cuyahoga County. His subject will be "Planning the



J. B. STOCKLEN, M. D.



M. G. BUCKLES, M. D.



W. L. POTTS, M. D.



D. W. HEUSINKVELD, M.D.



EDWIN P. JORDAN, M. D.



A. C. ERNSTENE, M. D.



ROBERT D. TAYLOR, M. D.

Management of the Patient with Tuberculosis," at 4 p. m. at the Chillicothe meeting.

Dr. Maurice G. Buckles, Columbus, thoracic surgeon, Franklin County Tuberculosis Hospital, and assistant clinical professor of thoracic surgery, Ohio State University College of Medicine. Dr. Buckles will speak at 4:30 p. m. at Chillicothe on "Developments in Chest Surgery."

Dr. Sidney E. Wolpaw, Cleveland, assistant clinical professor of medicine, Western Reserve University School of Medicine and assistant department head at the Tuberculosis Division of Cleveland City Hospital. His subject at 6:45 p. m., Chillicothe, will be "Drug Therapy—Streptomycin and Its Uses in Tuberculosis."

Dr. Arnold B. Kurlander, Columbus, chief of the Division of Tuberculosis, Ohio Department of Health, will discuss "Community Tuberculosis Control Measures," at 7:15 p. m. in Chillicothe.

Dr. Carl A. Wilzbach, Cincinnati, chairman of the Committee on Education of the Ohio State Medical Association, is chairman of the Chillicothe program.

Dr. A. Carlton Ernstene, Cleveland, director of the Department of Medicine, Cleveland Clinic, and president of the Cleveland Cardiovascular Society, will discuss "Coronary Heart Disease" at 2 p. m. and "Treatment of Congestive Heart Failure" at 5 p. m. at the Lima meeting.

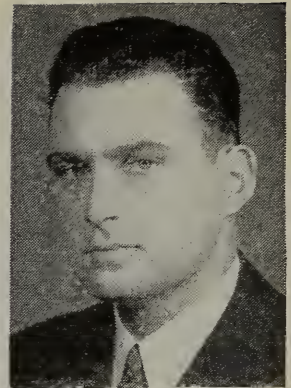
Dr. Robert D. Taylor, Cleveland, staff member of the Division of Research, Cleveland Clinic, will speak on "Hypertensive Cardiac Disease" at 2:45 p. m. and on "Cardiac Surgery" at 4:30 p. m. at the Lima course.

Dr. Harold Feil, Cleveland, clinical professor of medicine, Western Reserve University School of Medicine, will discuss "Rheumatic Heart Disease and Bacterial Endocarditis" at 3:15 p. m. and "Cardiac Surgery" at 4:30 p. m. during the Lima program.

Dr. Edwin P. Jordan, Cleveland, member of the Committee on Education of the Ohio State Medical Association, is chairman of the Lima seminar.

Dr. Edward P. Cawley, Ann Arbor, Mich., assistant professor of dermatology and syphilology, University of Michigan Medical School, will open the Mansfield program with the subject "Common Dermatological Disorders of a Primary Nature," and will speak on "Deep Mycoses" at 4 p. m.

Dr. Arthur C. Curtis, Ann Arbor, Mich., professor and chairman of the Department of Dermatology and Syphilology, University of Michigan Medical School, will discuss "Contact Dermatoses" at 2:15 p. m. and at 4:30 p. m. will speak



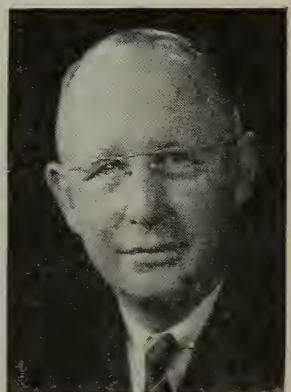
A. B. KURLANDER, M. D.



HAROLD FEIL, M. D.



E. P. CAWLEY, M. D.



ARTHUR C. CURTIS, M. D.

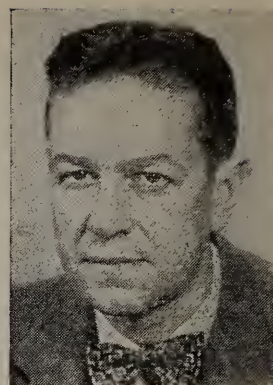


THOMAS E. RARDIN, M. D.

on the subject "Cutaneous and Subcutaneous Manifestations of Systemic Disease."

Dr. Sture A. M. Johnson, Madison, Wis., professor and head of the department of dermatology and syphilology, University of Wisconsin School of Medicine, will speak on "Common Bacterial and Viral Infections of the Skin" at 2:45 p. m. and on "A Review of Advances in Dermatologic Management" at 7 p. m. in Mansfield.

Dr. Thomas E. Rardin, Columbus, member of the Committee on Education of the Ohio State Medical Association, is chairman of the Mansfield program.



S. A. M. JOHNSON, M. D.

Stresses Need of Caution In New Cancer Tests

Physicians, especially those who read the scientific article in the September issue of *The Journal* entitled, "Papanicolaou Test in the Early Diagnosis of Uterine Cancer," will be interested in a further caution which appeared in the September issue of the *Journal of the A. M. A.*

The caution in the use of two comparatively new tests for early cancer of the cervix was issued by Dr. J. Ernest Ayre, of the Cancer Research Division, Gyne-cytology Laboratory, Royal Victoria Hospital, McGill University, Montreal, Canada.

Dr. Ayre emphasizes the problem—insuring adequate protection of women against cancer and yet preventing needless radical surgery—which results of the "smear" and "surface biopsy" tests may present to the physician.

Successful treatment of cancer of the cervix, like that of other cancer, depends on early diagnosis and prompt medical or surgical care. Early diagnosis, however, has been difficult in cancer of the cervix because by the time women became sufficiently aware of symptoms to seek the help of a physician, the growth is often far advanced.

The two tests, based upon examination of cells from the body, enable physicians to place in the surgeon's hands many early cancerous conditions in which the lesion is microscopic in size, Dr. Ayre says.

The "smear" test for diagnosing early cancer of the uterus and cervix was developed by George N. Papanicolaou, M. D., of the Departments of Anatomy and of Gynecology and Obstetrics of the Cornell University Medical College and the New York Hospital, New York City. Describing the test, Dr. Papanicolaou says:

"Cells at the surface of the growth tend to be dislodged. A technique for collecting the cellular debris, smearing it upon glass slides, and staining it has been perfected, so that the various components may be studied. The method is so

simple and inexpensive that it may be applied to large numbers of women.

"The interpretation of the smear requires the services of a careful and discriminating cytologist who has had experience in this field."

Dr. Ayre, who developed the "surface biopsy," says that the technique consists of scraping cells from the suspected early cancer or pre-cancerous tissue.

"The cells are then transferred to a glass slide, and the smear is prepared in the usual fashion," he explains, adding:

"It must be recognized that it is a highly specialized technique requiring precision and care in the taking of the tests, skill in the staining, and experienced judgment on the part of the cytologist.

Biopsy—examination of samples of tissue under a microscope—may fail to confirm the findings of the "smear" and "surface biopsy" tests in cases of growths too small to be seen by the eye, according to Dr. Ayre.

"Danger rests in the possibility that a negative result of biopsy, with no further investigation, may lead to fatal delay, permitting a beginning cancer to develop into a potentially incurable one before treatment is instituted," he comments.

"On the other hand," Dr. Ayre continues, "it is almost equally important to prevent needless major operation, especially during the years in which a woman may bear children."

In cases in which extremely early growths are indicated by the "smear" and "surface biopsy" tests and in which the biopsy fails to give a diagnosis of cancer, an amputation rather than radical surgery is advisable, Dr. Ayre believes.

The "great sensitivity" and accuracy of the "surface biopsy" test in following up cases "month by month and year by year" should permit an early enough recognition of recurrence of the disease to allow radical surgery or X-ray treatment before a dangerous spread of the growth occurs, he says.

In Memoriam . . .

Carl Wilson Brown, M.D., Lancaster; Ohio State University College of Medicine, 1910; aged 60; died August 12; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Fairfield County Medical Society in 1924, chairman of its legislative committee in 1925-26, and secretary-treasurer from 1927 to 1948. Dr. Brown was a native of Lancaster where he moved his practice from Bremen in 1923. For 25 years he was chief medical consultant at the State Boys' Industrial School and until recently was a member of the Fairfield County Board of Visitors. For the past 10 years he was physician in charge at Anchor Hocking Glass Corporation's two plants and served in similar capacities for the Manufacturers Battery Co., and Hocking Valley Manufacturing Co. During World War I he served overseas with the Army Medical Corps. He was a member of the American Legion, Veterans of Foreign Wars, the Presbyterian Church, Lancaster Country Club, and was a past-president of the Kiwanis Club. Surviving are his widow, a son and daughter, a brother and two sisters.

George Lewis Cable, M.D., Athens; Starling Medical College, Columbus, 1897; aged 75; died August 18; in a Denver, Colo., hospital. Surviving are three brothers and two sisters.

Michael H. G. Carmody, M.D., Painesville; Cleveland Medical College, Homeopathic, 1897; aged 71; died August 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Carmody was recognized by the Lake County Medical Society last year as having attained 50 years of practice. One of his favorite hobbies was extensive travel. He was a member of the Catholic Church. Surviving are his widow and three sons, including Dr. Morris G. Carmody also of Painesville.

Samuel Earl Eagon, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1915; aged 58; died August 7; former member of the Ohio State Medical Association and the American Medical Association through 1931. Dr. Eagon practiced for approximately 36 years in Cincinnati. He was a veteran of World War I and belonged to the Masonic Order. Surviving are two sisters.

Wiley DeBarr Hickey, M.D., Leipsic; University of Michigan Medical School, 1900; aged 73; died August 28; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Putnam County Medical Society in 1934, and a delegate from that society to the Ohio State Medical

Association 1936-38 and 1941. Dr. Hickey practiced medicine in Leipsic for 45 years until his retirement about three years ago. He was a member of the Masonic Lodge and the Church of Christ. Surviving are his widow and a daughter.

Charles Franklin Junkermann, M.D., Columbus; Hahnemann Medical College and Hospital, Chicago, 1889; aged 86; died August 29; former member of the Ohio State Medical Association and the American Medical Association in 1940 and 1941. After practicing in Nelsonville and Lancaster, Dr. Junkermann moved to Columbus in 1910. He was a member of the American Institute of Homeopathy and Ohio State Homeopathic Society. Surviving are his widow; two sons, Dr. Edgar B. Junkermann and Dr. Carl S. Junkermann, both of Columbus; two daughters, a brother and two sisters.

Gregory F. Lukianoff, M.D., New York City; Columbia University College of Physicians and Surgeons, 1923; aged 52; died August 31; former member of the Ohio State Medical Association and the American Medical Association through 1941. Dr. Lukianoff practiced in Lorain before moving to New York about 10 years ago. Surviving are his widow, a son and a daughter.

Edward Winfield Miskall, M.D., East Liverpool; Ohio State University College of Medicine, 1926; aged 48; died August 13; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Columbiana County Medical Society in 1931. Dr. Miskall began practice in East Liverpool in 1927. He was a fellow in the American College of Physicians, a diplomate of the American Board of Internal Medicine, consultant in Salem City Hospital, and a member of the East Liverpool City Hospital Staff. He was a member of the Catholic Church. Surviving are his widow, three sisters and a brother.

Walter Kearnes Nihart, M.D., Edgerton; Michigan College of Medicine and Surgery, Detroit, 1906; aged 69; died August 20; former member of the Ohio State Medical Association and the American Medical Association through 1919. Dr. Nihart practiced medicine in Edgerton for 42 years. Surviving are his widow, a son, a daughter, two brothers, and a sister.

Vera Viola Norton, M.D., Waverly, Iowa; Northwestern University Woman's Medical School, Chicago, 1899; aged 71; died August 11; former member of the Ohio State Medical Association and a Fellow of the American Medical

Association through 1941; member of the American College of Chest Physicians. Dr. Norton was associate medical director for Dunham Hospital, Cincinnati, until her retirement in 1941.

Alfred Pulford, M. D., Toledo; Cleveland University of Medicine and Surgery, 1885; aged 85; died August 4; Dr. Pulford practiced medicine for 62 years, 49 years of which were spent in Toledo. He was a member of several Masonic orders. Surviving are his widow, a son, Dr. Dayton T. Pulford also of Toledo.

Miles Jerome Scott, M. D., Batavia; University of Cincinnati College of Medicine, 1925; aged 49; died August 14 as the result of injuries received in a fall; former member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Scott was medical director of the Hamilton County Chronic Disease Hospital from 1936 to 1941, and in 1943 moved his practice to Batavia. He was a veteran of World War I, was a member of the American Legion and the Masonic Lodge. Surviving are his widow and two daughters.

Eugene Charles Stern, M. D., Lakewood; University of Goettingen, Germany, 1919; aged 54; died July 12; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Stern practiced in Germany before coming to the United States in 1937. He was a member of the American Academy of Dermatology and Syphilology, the Cleveland Dermatological Society and the Central State Dermatological Association. He is survived by his widow.

George Elmer Strahler, M. D., Dayton; Indiana University School of Medicine, 1909; aged 63; died August 26; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Strahler practiced his profession in Dayton for the past 39 years. He was a member and active worker in the Evangelical United Brethren Church and was former director and physician of the Door of Hope Society. Surviving are his widow, a son, three daughters and two brothers.

Frank Ulmer Swing, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1904; aged 75; died August 3; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947; diplomate of the American Board of Otolaryngology; member of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology. Dr. Swing practiced his profession in Cincinnati since the completion of his education. He was a member of the Army Medical Corps during World War I. Surviving are his widow, two brothers and a sister.

James Craven Wood, M. D., Cleveland; University of Michigan Homeopathic Medical School, 1879; member of the Ohio State Medical Association, the American Medical Association and the American College of Surgeons. Although he retired from active surgery about 15 years ago, Dr. Wood continued to maintain his office and to practice medicine. He was the author of several medical text books, was past president of the American Institute of Homeopathy and the Michigan and Ohio State Homeopathic Medical Societies. Surviving is one son.

Will C. Braun Dies

Will C. Braun, who retired as business and circulation manager of the American Medical Association in 1946 after 54 years service, died Sunday, Sept. 12, in Chicago. He is survived by his wife, Lulu; a daughter, Mrs. Harrie Hall, of Evanston; and his son, George, of Wilmette, Ill. Funeral services were held Sept. 14 in Evanston and burial was at Ripley, Ohio, where he was born in 1868.

Schering Announces Research Grants

Five new research studies in the field of hormone therapy, X-ray diagnostics, and allergy, instituted under grants from Schering Corporation have been announced by Mr. Francis C. Brown, president of the Company. The grants are part of the expanding program of research of the Bloomfield, N. J., pharmaceutical manufacturers.

The studies will be as follows: Encephalography in allergic children, New York Post-Graduate Hospital; utilization and absorption of the female sex hormones, progesterone, estradiol and estradiol benzoate, by routes other than injection, Cornell University Medical College, New York Medical College and Metropolitan Hospital Research Unit; the metabolism, absorption and excretion of the gallbladder diagnostic agent, Priodax, and related compounds, Yale University School of Medicine; and effect of the male hormone preparations of testosterone in thyrotoxicosis, Addison's disease and Cushing's disease, University of Washington School of Medicine.

Hygeia Subscription Rates Are Increased

The A. M. A. Board of Trustees has authorized an increase of subscription prices for *Hygeia*, the health magazine of the A. M. A., as follows: single copy from 25 to 35 cents; one year from \$2.50 to \$3.00; two years from \$4.00 to \$5.00; and three years from \$6.00 to \$6.50. The new prices, occasioned by the increase in costs of material and labor, will go into effect on November 1.



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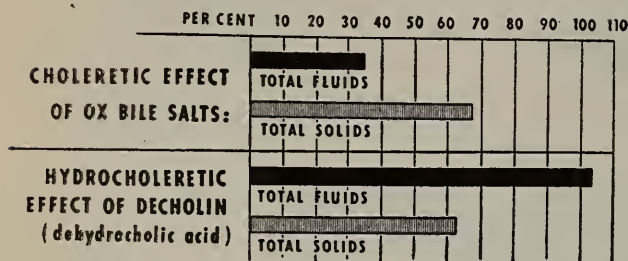


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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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Buckeye News Notes . . .

Cleveland—Dr. Francis E. Merritt has been promoted from assistant to full clinical director of the Cleveland State Receiving Hospital and Dr. Brian Bird, assistant professor of psychiatry at Western Reserve University, has been designated educational director.

Cleveland—Dr. Irvine H. Page, director of research, Cleveland Clinic Foundation, has been appointed one of 12 members of the National Advisory Heart Council.

Cleveland—Dr. Roscoe J. Kenndey is the new head of the Department of Ophthalmology at the Cleveland Clinic. He has been with the clinic since 1937.

Cleveland—Dr. F. William Sunderman has been appointed head of the Department of Clinical Pathology at the Cleveland Clinic Foundation.

Columbus—Dr. Floyd M. Green recently spoke before the Life Office Managers Association meeting in Chicago on the subject "Guaranteeing the Health of Office Workers."

Lakewood—Dr. John A. Toomey, Cleveland, recently addressed the Lakewood Rotary Club.

Lancaster—Dr. W. D. Nusbaum, Orchard Hill, was appointed a member of the medical staff at the Anchor Hocking Glass Corporation.

Middletown (Butler County)—Dr. Mabel E. Gardnes spent a two weeks' vacation by flying to the British Isles.

Troy—Dr. Burton M. Hogle recently addressed the Rotary Club on the subject of modern advances in surgery.

Versailles—Dr. W. C. Gutermuth recently was honored at a community gathering for having served more than 50 years as a practicing physician.

West Union—The Adams County Medical Society held its regular monthly meeting on August 19, with Dr. Ralph W. Eddy, Cincinnati, speaking on "Pelvic Inflammatory Diseases."

Youngstown—Dr. William H. Bunn, addressed the Kiwanis Club on the subject of heart diseases.

Activities of The Editor

Following are some of the activities recently engaged in by Dr. Jonathan Forman, Editor of *The Journal*.

Addressed the teachers in attendance at the State Teachers Conservation Laboratory and the Future Homemakers encamped at Jackson's Mills State Park, West Virginia.

Was author of an article "Writing for Radio" which appeared in the July Bulletin of the Columbus Academy of Medicine.

New Set-Up for 1949 A. M. A. Program Is Approved

A reduction and reallocation of scientific meetings for the 1949 Annual Session was voted by the Council on Scientific Assembly at its recent meeting in Chicago.

According to the Council, it was very apparent for some time that the large number of scientific meetings exhausted the restricted facilities available in the convention cities, and that in many instances the relatively small attendance at some sections did not justify the number of meetings allocated.

The Council voted to: (1) retain three section meetings for the Sections on Internal Medicine, Surgery, Pediatrics, Obstetrics and Gynecology and on the General Practice of Medicine, and, (2) to reduce all other sections to two meetings with the exception of Preventive and Industrial Medicine and Public Health, which was reduced to one. The new session on Diseases of the Chest was allotted two meetings. Two sessions on Physical Medicine and one on Allergy, which come under the Section on Miscellaneous Topics, were also approved.

Opinion of Attorney General

The following is an abstract of a recent opinion rendered by Attorney General Hugh S. Jenkins:

Syllabus of Opinion No. 3226: "Where an indigent person is in the State of Ohio and has the intention of remaining in Ohio, or meets the requirements for residence, the county commissioners of the county where such person resides can legally pay for hospitalization in a district tuberculosis hospital."

Postgraduate Courses

The University of Michigan Medical School, Ann Arbor, has announced two courses in January as part of its postgraduate program.

"Application of the Basic Sciences to Clinical Medicine," is the title of a course to be given January 3-29. This program will correlate the basic sciences with clinical medicine.

A "Urology Conference" will be held January 19-20, under sponsorship of the Detroit Urological Society.

Information may be obtained from Dr. Howard H. Cummings, chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Mich.

Applications are being accepted for the 1950 written test of the American Board of Ophthalmology. Registration is closed for the next test to be given in January, 1949.



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, *Amer. J. Clin. Pathology*, 14:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, *J. Amer. Med. Tech.*, 8:606-14 (Sept.) 1947.

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Tuberculosis Division . . .

With 8,000 New Cases In One Year Reported In State, Central Office Directs Fight Against No. 1 Communicable Disease Killer

THE Tuberculosis Division of the Ohio Department of Health is the oldest of such divisions in the Nation. It was created in 1913. However, within a few years after the division had been created, its activities had to be curtailed because of a lack of funds. Several years ago when Federal grants-in-aid became available, the division was reactivated and it is now one of the most active units of the department.

Today the picture of control of tuberculosis in the state is optimistic, but not as ideal as might be expected with that early start. The death rate from tuberculosis per 100,000 population has been reduced from 150 in 1910 to 30 in 1947. Ohio's rate, however, is just about average compared with rates of the other states.

Tuberculosis, with 2,363 deaths in the State during 1947, far outranks other communicable diseases as a killer. For every death from measles during 1945 there were 18 from tuberculosis; for every death from whooping cough there were 29 from tuberculosis; for every death from scarlet fever, 61 from tuberculosis; for every death from diphtheria, 80 from tuberculosis, and for every death from typhoid fever, there were 160 from tuberculosis. Tuberculosis outranks all other causes of deaths in the so-called maximum productive years from 19 to 45.

During 1947 the Division placed on record 8,003 new cases of tuberculosis in the State. Officials believe, however, that this figure is high, and represents some duplication of formerly reported cases. In addition, there are about 30,000 cases on file.

Health officials emphasize the need for more uniform hospitalization eligibility requirements in the different counties. Because of intercounty residence changes, many persons lose their eligibility for hospitalization, although they may continue to reside in the State.

Public health officers further point to the need for aid to breadwinners suffering from tuberculosis. More than 30 per cent of patients hospitalized during 1947 left hospitals against medical advice. This suggests that there has been insufficient patient and public education and inadequate financial protection for families of the tuberculous.

CASE FINDING ACTIVITIES

Increased emphasis has been placed on mass case finding in many areas of the state, but health authorities hasten to mention that in some instances case finding has become an end in itself rather than a means to more adequate control.

This is another in a series of articles on the organization, functions and programs of the Ohio Department of Health and its subdivisions, under Dr. John D. Porterfield, director. Previous articles include summaries on the reorganization of the Department, the Cancer Division, Child Hygiene Division, Vital Statistics Division, and the Hospital Facilities Office.

There are approximately 50 fluorographic units in operation throughout the State. Thirty-five of these units are stationary in type and 15 are mobile or portable. Of the entire number, 25 units are owned by the Ohio Department of health. Three 70 mm. mobile X-ray units are operated by the Department.

It is estimated that 300,000 chest pictures were taken during 1947. The Division can accurately account for 125,000 X-rays which were taken by the Department's mobile units. In all areas in which these units operated the 14 x 17-inch recheck X-rays were the responsibility of local health departments.

It is estimated that follow-up results are known on more than 75 per cent of the total number of persons X-rayed. It is the policy of the Division to refer all discovered active cases to family physicians or to local health departments.

CONSULTATION SERVICES

The Division provides consultation services with reference to tuberculosis control and general public health principles, procedures and methods to the following groups and agencies:

1. Local health departments;
2. Department of Public Welfare, Division of Mental Hygiene, including personal contacts with superintendents of mental and correctional institutions;
3. The State Department of Education, with reference to approval of home instruction for homebound tuberculous children;
4. State auditor, with reference to the tuberculosis subsidy;
5. District Office of the Veterans Administration; and
6. State and local tuberculosis and health associations.

In addition, the chief and assistant chief participate in lectures and demonstrations to local medical societies, medical students and state and

local health and nursing federations and associations.

BCG PROGRAM

The BCG vaccination program has been initiated in mental and correctional institutions in cooperation with the United States Public Health Service and the Ohio Department of Welfare, Division of Mental Hygiene. This program began in June among 11,500 inmates of four state welfare institutions—the Columbus State School, the Columbus State Hospital, Ohio Penitentiary and the Orient State School.

BUDGET

The Tuberculosis Division operates entirely on a Federal grant-in-aid appropriation of \$266,000 annually. No specific appropriation to the Division is included in the State's general appropriation to the Department. The \$3,566,250 recently made available to the Ohio Legislature to provide hospitalization for tuberculosis patients is not a function of the Department. The subsidy is administered to counties by the State auditor on the basis of \$2.50 per day per hospitalized tuberculous patient.

On the basis of the number of active cases in the State, there is a need of approximately 5,900 hospital beds. Actually there are about 3,300. Between 2,000 and 2,500 additional beds would enable health authorities to do an adequate job of hospitalizing patients.

The Hill-Burton law made available grant-in-aid federal funds for construction of hospitals and presupposes a certain percentage of hospitals for tuberculosis patients. The law offers to match one-third of Federal funds against two-thirds of local funds. The 87-bed Richland County Tuberculosis Sanitarium at Mansfield is the first tuberculosis project approved under this law.

The Ohio Department of Health suffered grave disappointment in its expectations for the proposed 300-bed tuberculosis wing to the Medical Center at Ohio State University. Construction was postponed when bids exceeded estimates by almost \$800,000.

PERSONNEL

Chief of the Tuberculosis Division is Dr. Arnold B. Kurlander, who came to the Ohio Department of Health in January, 1947, as a loan from the U. S. Public Health Service in which he is a commissioned medical officer. He is a graduate of Ohio State University College of Medicine and has had postgraduate training at the University of Michigan.

The central administration staff of the Division consists of 11 persons including technicians of mobile units. In addition to the central staff, the Department of Health pays out of Federal tuberculosis grant-in-aid the salaries of 66 persons in local health departments.

Public Relations Conference Scheduled Nov. 27

A national Medical Public Relations Conference, the first of its kind ever held, will tackle six common objectives on the eve of the American Medical Association Interim Session in St. Louis. The conference will be held on Saturday, November 27, under sponsorship of the A. M. A. Representatives of state and local medical societies have been invited.

The annual conference of Secretaries and Editors of state medical associations will be held on Sunday and Monday, November 28 and 29. The Interim Session runs from November 30 to December 3.

The Ohio State Medical Association will be represented at both conferences.

Goiter Association

The American Goiter Association again offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essay submitted concerning original work on problems related to the thyroid gland. Information may be obtained from Dr. T. C. Davison, 207 Doctors Bldg., Atlanta 3, Ga.



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Dr. Hennessy Named Secretary Of National Emergency Council

Dr. Harold R. Hennessy, who has been associated with the A. M. A. Council on Industrial Health since February, 1946, has been assigned as full-time secretary of the A. M. A. Council on National Emergency Medical Service, which is headed by Dr. James C. Sargent of Milwaukee, Wis.

Dr. Hennessy's position is a newly-created office, made necessary by the flood of work which is facing the council.

Dr. Smiley on New Post

Dr. Dean F. Smiley, who has been employed as consultant in health and fitness in the A. M. A.'s Bureau of Health Education since August, 1946, has resigned his position to work with the Association of American Medical Colleges.

Society for Crippled Children To Meet Oct. 30-31

The 29th annual meeting of the Ohio Society for Crippled Children will be held Saturday and Sunday, October 30 and 31, at the Hotel Deshler-Wallick, Columbus. Meetings will be open to the public.

A preliminary program of speakers and subjects will be available after October 1 at the organization's headquarters, 5 W. Broad St., Columbus 15.

The 28th annual convention of the National Society for Crippled Children and Adults, Inc., will be held at the LaSalle Hotel; Chicago, November 15-17.

Marriages, Divorces Still High

The numbers of marriages and of divorces in the United States in 1947 were well above pre-war levels, although both dropped below the all-time highs recorded in 1946, according to provisional figures released by Oscar R. Ewing, Federal Security Administrator. There were 1,992,354 marriages in 1947, compared to a revised total of 2,291,045 marriages in 1946. In terms of crude rates, there were 13.9 marriages in 1947 per 1,000 population, and 16.4 in 1946.

The provisional number of divorces in 1947 was 471,000, compared to a revised total of 610,000 divorces in 1946. The divorce rates per 1,000 population were 3.3 in 1947 and 4.3 in 1946.

Veterans on Veterans Administration compensation and pension rolls on August 1 included 43 who served in the Civil War; 698, the Indian Wars; 106,164, the Spanish-American War; 448,228, World War I; 43,317, the Regular Establishments, and 1,678,861, World War II.

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Activities of County Societies . . .

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

At the Sept. 10 meeting of the Miami County Medical Society, Dr. Melvin Oosting of the Miami Valley Hospital gave a report on the program of laboratory procedure, a joint program in cooperation with the Miami County Chapter of the Cancer Society. Other subjects discussed included the Red Cross Blood Bank and the tuberculosis program. A motion picture, "Occupational Health Problems," was shown.

MONTGOMERY

The Montgomery County Medical Society sponsored an educational exhibit on the subject "Know Your Heart" at the Montgomery County Fair, Sept. 6-9. The committee which planned and carried out the project was composed of Dr. W. A. Reiling, chairman; Dr. D. C. Elliott and Dr. F. L. Shively, Jr.

Third District

(COUNCILOR: J. CRAIG ROWMAN, M. D.,
UPPER SANDUSKY)

LOGAN

Dr. Hobart L. Mikesell, West Liberty, talked

on diabetes at the Sept. 3 meeting of the Logan County Medical Society which was held at the Mary Rutan Hospital. Members voted to recommend a blood donor program to the Logan County Chapter of the American Red Cross. It was announced that a small medical library had been started at the hospital with books donated by physicians.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

A symposium on the treatment of hyperthyroidism with three guest speakers was held at the Sept. 17 meeting of the Academy of Medicine of Cleveland. The guests and aspects on which they spoke were: Dr. John deJ. Pemberton, Rochester, Minn., "Surgical Treatment"; Dr. Willard O. Thompson, Chicago, Ill., "The Role of Thiourea Compounds," and Dr. Saul Hertz, Boston, Mass., "The Use of Radioactive Iodine."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

PORTAGE

Dr. Richard S. Knowlton, Cleveland, spoke on

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"Jaundice" at the Sept. 2 meeting of the Portage County Medical Society at the Robinson Memorial Hospital, Ravenna. Dr. Theodore E. Tetreault of Kent has accepted a teaching position in the University of Minnesota.

SUMMIT

"The Newer and Better Therapeutic Agents and Drugs" was the topic of a talk by Dr. A. H. Aaron, University of Buffalo Medical School, at the Sept. 9 meeting of the Summit County Medical Society. The meeting was held in the Nurses' Home of City Hospital, Akron.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

A program by the staff of Bellaire City Hospital was presented at the meeting of the Belmont County Medical Society Meeting on Sept. 16.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

MUSKINGUM

"Interpretation of Laboratory Findings in Relation to Clinical Medicine," was the subject of an address by Dr. Emmerick von Haam, Ohio State University College of Medicine, at the Sept. 8 meeting of the Muskingum County Academy of Medicine at the University Club Rooms, Zanesville.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

Dr. Carl A. Lincke, Carrollton, President-Elect of the Ohio State Medical Association, was guest speaker at the Sept. 14 meeting of the Lorain County Medical Society at the Spring Valley Country Club, Elyria.

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

STATE BOARD MEETING

The Annual Fall Board Meeting and Conference of presidents, presidents-elect, officers, and chairmen of state committees of the Woman's Auxiliary to the Ohio State Medical Association will be held at the Seneca Hotel, Columbus, October 18 and 19.

The Board meeting will begin with dinner at 6:00 p. m. on Monday, October 18, at the Seneca Hotel.

On Tuesday, October 19, at 10:30 a. m., there will be a business session for county presidents,

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presidents-elect, and State Board members. Mrs. E. Benjamin Gillette will preside.

SUMMIT

Mrs. J. Paul Sauvageot became the new president of the Woman's Auxiliary to the Summit County Medical Society when the group met in May for their annual luncheon. Mrs. Frank M. McDonald is the president-elect, and Mrs. Robert M. Lemmon, the retiring president.

In June, the Medical Society and its Auxiliary had a picnic and square dance. July 15, the Ways and Means Committee headed by Mrs. Carl C. Nohe raised \$3,000 for a Nurses' Scholarship Fund by means of a garden party. The annual membership tea was held September 10 at the home of Dr. and Mrs. S. A. Schleuter. Forty-two new members were welcomed. The proceeds from five suits designed by Susan Garber were given for the benefit of the Nurses' Scholarship Fund. At the tea the suits were modeled.

TUSCARAWAS

Forty-two physicians and their wives were present at the annual covered-dish supper of the Tuscarawas County Medical Society held at the home of Dr. and Mrs. R. J. Foster in New Philadelphia, August 11. Among those present were Dr. Carl A. Lincke, president-elect of the Ohio State Medical Association, and Mrs. Lincke, of Carrollton. Dr. S. H. Winston showed two very interesting colored sound films—one a travelogue through the northwest and the other of tree farms.

On September 9, the regular meeting of the Auxiliary was held at the home of Mrs. F. C. Yeager of Dover. Roll call was responded to by articles of medical interest. Five dollars will be sent to the Nurses' Loan Fund of Ohio. Plans were made and committees were appointed for the luncheon meeting of the Seventh District which will be held at the Union Country Club, Tuesday, October 5. The State Auxiliary President, Mrs. E. Benjamin Gillette, and other state officers will be present.

The following officers for the coming year were elected: president, Mrs. M. W. Everhart, New Philadelphia; president-elect, Mrs. W. R. Stager, Dover; vice-president, Mrs. C. J. Miller, New Philadelphia; secretary, Mrs. J. W. Hamilton, Dover; and treasurer, Mrs. William E. Hudson, New Philadelphia. At the close of the business session, lunch was served by the hostess, Mrs. Yeager.

Potteries Name Medical Director

Six potteries located in East Liverpool and Wellsville, Ohio, and in Chester and Newell, W. Va., employing approximately 6700 persons, announce the appointment of Dr. Joseph T. Noe, of East Chicago, Ind., as the new medical director for the group.

The group plan of medical supervision was initiated three years ago under the direction of Dr. Elmer F. Herring, who resigned August 1, to specialize in chest work in San Fernando, California. Dr. Noe is a graduate of the University of Louisville, Ky., Medical School and served as a major in the Army Medical Corps during World War II.

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OCTOBER 15 and 16, 1948

PROGRAM

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1. "Infertility: Collaboration of the Specialists"
Dr. David Weir and Staff, Cleveland
2. "Counseling and Education for Marriage"
Dr. Frank F. Tallman, Columbus
3. "In What Direction Are Counseling Methods Leading?"
Carl R. Rogers, Ph.D., Chicago University
4. "How to Secure and Maintain Clinical Records for Research Purposes"
Dr. I. E. Kling, M.P.H., New York City

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Veterans Administration . . .

Veterans Administration urged all veterans, who were treated for syphilis with penicillin during service in the armed forces, to undergo periodic check-ups so as to prevent recurrence of the disease.

Between 20 and 30 per cent of the cases treated with penicillin are reported to be "failures," contrary to the popular belief that the drug is a "cure all" for venereal disease, Dr. Bascom Johnson, Jr., assistant chief of dermatology and syphilology in V. A.'s Department of Medicine and Surgery, declared.

* * *

Veterans Administration has immediate openings for at least one hundred young doctors interested in taking residency training in psychiatry or neurology or both, Dr. Paul B. Magnuson, chief medical director, announced.

V. A. hospitals offering these residencies are situated in almost every section of the country. All are under supervision of the deans' committees, mostly composed of members of university faculties of Class "A" medical schools.

In general, these residencies cover a three-year program of specialty training, although one and two-year programs also are available at most of the hospitals.

Junior or first year residents must have completed a satisfactory internship and be considered ready for specialization. Intermediate or second year residents must have the qualifications of a junior resident and the equivalent of one year's training in the specialty. Senior residents must have the qualifications of a junior resident and two years' training in the specialty.

Interested doctors may obtain information and application forms regarding the residencies by writing the Chief Medical Director, Veterans Administration, Washington 25, D. C.

* * *

Approximately 15,000 doctors, dentists, and nurses in Veterans Administration Department

of Medicine and Surgery received annual wage increases of \$330 effective July 11. Professional employees of V. A.'s Department of Medicine and Surgery are exempt from the provisions of the Civil Service, except for retirement benefits, and the increase will be paid from regularly appropriated funds.

* * *

A total of 3,035 beds in Army hospitals throughout the United States have been allocated for treatment of veterans, Major General Raymond W. Bliss, Surgeon General of the Army, announced. The allocations were made at the request of the Veterans Administration.

Beds allotted for veterans may be used partly for treatment of chronic disabilities, with 325 set aside specifically for tuberculosis cases at Fitzsimons General Hospital in Denver. None of the beds allocated will be used for patients who could be treated in domiciles.

* * *

Contract for the construction of a 131-bed addition to the present Veterans Administra-

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tion hospital at Brecksville, Ohio, has been awarded to D. H. Dave, Inc., Frank E. Freeman, Inc., and Kane Associates, of Brooklyn, on their joint bid of \$937,000, V. A. announced.

* * *

The acquisition of 200 acres of Fort Funston, California, for a new 1,000-bed neuropsychiatric Veterans Administration hospital to serve the Bay area, has been approved.

* * *

Dr. Kenneth M. Smith, Columbus, O., physician, has been appointed Chief of General Medicine Division, Professional Services, for the V. A.'s Ohio-Michigan-Kentucky Branch Office in Columbus. He also will serve temporarily as assistant chief of the Branch Tuberculosis Division until a permanent appointment is made.

* * *

During the 12-month period ending August 1, a total of 15,636 veterans have been admitted to the four V. A. hospitals in Ohio. This is a monthly average of 1,303. In addition, 2,702 veterans have been admitted to the Dayton Domiciliary for a monthly average of 225. The number of veterans discharged has paralleled the admissions to a large extent.

* * *

During the year a total of 9,024 operations were performed in the four V. A. hospitals in Ohio, including 4,200 major and 4,824 minor operations.

* * *

In the use of shock therapy with mental patients at Chillicothe V. A. Hospital, 215 patients were treated with Insulin Shock during the year and 33 per cent of those treated have been discharged. Electric shock treatment was given 350 patients in the year and 43 per cent have been discharged.

* * *

A total of 529 Ohio claims for cost of unauthorized medical services, amounting to \$74,694, were received during the one-year period ending August 1 at the Veterans Administration Columbus Branch Office.

The claims resulted from the unauthorized medical care of veterans by Ohio physicians and by private hospitals in the state. Of the number of claims, 411 were allowed, totaling \$38,571. The V. A. Branch Office now has 124 pending claims in the amount of \$20,711.

V. A. officials emphasize that prior V. A. approval must be obtained by veterans in obtaining medical care on an out-patient basis.

Four points which must exist before an unauthorized claim may be considered favorably by V. A. are: (1) Treatment was for service-connected disability or was necessary to prevent interruption of training under Public Law 16; (2) treatment was rendered in a medical emer-

gency; (3) government facilities were not feasibly available; (4) a delay in treatment would have been hazardous.

* * *

Dr. Helen Hunscher, head of the Home Economics Department at Western Reserve University, Cleveland, Ohio, and president of the American Dietetic Association, has been appointed a member of Veterans Administration Special Advisory Group on medical problems.

Dr. Hunscher succeeds Miss Cathryn Ver Murlen, who resigned to accept a position with V. A.'s Atlanta, Georgia, Branch Office.

COMING MEETINGS

Ohio State Medical Association Postgraduate Course, "New Advances in the Treatment of Chest Diseases," Chillicothe, October 21.

Ohio State Medical Association Postgraduate Course, "Practical Cardiology," Lima, October 27.

Ohio State Medical Association Postgraduate Course, "Practical Dermatology," Mansfield, November 3.

Ohio State Medical Association Annual Meeting, Columbus, April 19-22, 1949.

American Medical Association Interim Session, St. Louis, Nov. 30-Dec. 3.

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9, 1949.

American College of Physicians, Annual Session, New York City, March 28-April 1, 1949.

American College of Surgeons, Los Angeles, Oct. 18-22.

American Public Health Association, Boston, Mass., Nov. 8-12.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 8.

Northwestern Ohio Medical Society Annual Session, Findlay, October 5.

Sixth Councilor District Post-Graduate Day, Mayflower Hotel, Akron, Oct. 13.

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Cincinnati Ophthalmologic Club

The Cincinnati Ophthalmologic Club announces an interesting program for the coming year. Beginning in October the Club will meet on the second Friday evening of each month.

The program will include as guest speakers: Dr. Herman M. Burian, Boston, on October 8; Dr. Peter C. Kronfeld, Chicago, on January 14; Dr. Alston Callahan, Birmingham, Ala., on February 11; Dr. Derrick T. Vail, Chicago, on April 8; Dr. Harold F. Scheie, Philadelphia, on May 13.

Officers of the Club for the year 1948-1949 are: Presidium: Drs. Donald J. Lyle, Ira Abrahamson, Karl W. Ascher.

Secretary: Dr. Josef D. Weintrub, 712 Provident Bank Bldg., Cincinnati 2, Ohio.

Historian: Dr. K. L. Stoll.

Committee appointments for the year 1948-1949:

Program Committee: Drs. K. W. Ascher (chairman), George B. Heidelman, Albert L. Brown, and Francis X. Siegel.

Committee on Clinical presentations: Drs. Ira A. Abrahamson (chairman), Richard A. Hoffman, Barnet R. Sakler, Cyril E. Schrimpf, and Morris S. Osher.

Dinner and Hospitality Committee: Drs. Donald J. Lyle (chairman), Horace W. Reid, Charles A. Hofling, and Louis J. Hendricks.

Program Committee: Medical Ophthalmology—Drs. K. W. Ascher and Richard A. Hoffman; Surgical Ophthalmology—Drs. A. M. Culler and Ralph H. Miller.

Parran To Head New Public Health School at Pittsburgh

The University of Pittsburgh has announced acceptance of a \$13,600,000 gift from the A. W. Mellon Educational and Charitable Trust for a new Graduate Public Health. Simultaneously, Chancellor R. H. Fitzgerald of the University announced the appointment of Dr. Thomas Parran, former Surgeon General of the U. S. Public Health Service, as the first dean of the new school and as consultant to the chancellor on the medical sciences. Dr. Parran will assume his new position immediately. Efforts will be made to have the school begin operation in the Fall of 1949.

According to the terms of the gift, the school

will receive an initial endowment of \$4,000,000 and additional funds over a five-year period, as the School develops, to a total of \$13,600,000.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Price covers the cost of remaining answers. Forms close 16th of the month preceding publication.

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FOR SALE: Equipment of retired eye, ear, nose and throat specialist, in excellent condition, including: Ophthalmic chair, examining and treatment chair, test cabinet, trial case, ophthalmoscope, sterilizer; various other types of equipment and many instruments. F. J. Hunter, M.D., 292 East Center Street, Marion, Ohio.

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BRIEF HISTORICAL NOTES ON MEAD'S CEREAL, PABLUM AND PABENA

HAND in hand with pediatric progress, the introduction of Mead's Cereal in 1930 marked a new concept in the function of cereals in the child's dietary. For 150 years before that, since the days of "pap" and "panada," there had been no noteworthy improvement in the nutritive quality of cereals for infant feeding. Cereals were fed principally for their carbohydrate content.

The formula of Mead's Cereal was designed to supplement the baby's diet in minerals and vitamins, especially iron and thiamine. How well it has succeeded in these functions may be seen from two examples:

(1) As little as one-sixth ounce of Mead's Cereal* supplies over 50% of the iron and 20% of the thiamine minimum requirements of the 3-months-old infant. (2) One-half ounce of Mead's Cereal furnishes all of the iron and 60% of the thiamine minimum requirements of the 6-months-old baby.

That the medical profession has recognized the importance of this contribution is indicated by the fact that cereal is now routinely included in the infant's diet as early as the third or fourth month instead of at the sixth to

twelfth month as was the custom only a decade or two ago.

In 1933 Mead Johnson & Company went a step further, improving the Mead's Cereal mixture by a special process of cooking, which rendered it easily tolerated by the infant and at the same time did away with the need for prolonged cereal cooking in the home. The result is Pablum, an original product which offers all of the nutritional qualities of Mead's Cereal, plus the convenience of thorough scientific cooking.

During the last twelve years, these products have been used in a great deal of clinical investigation of various aspects of nutrition, which have been reported in the scientific literature.

Many physicians recognize the pioneer efforts on the part of Mead Johnson & Company by specifying Mead's Cereal and PABLUM—and also the new Pablum-like oatmeal cereal known as PABENA.

*Pablum, the precooked form of Mead's Cereal, has practically the same composition: wheatmeal (farina), oatmeal, cornmeal, wheat embryo, beef bone, brewers yeast, alfalfa leaf, sodium chloride, and reduced iron.

Reliance on MAPHARSEN is reflected in its extensive clinical use — over 200,000,000 injections since 1940. The significant advantages of high therapeutic effectiveness and notable relative safety have established its value as an antispirochetal agent. Clinical and serological follow-ups continue to demonstrate its high percentage of cures. Equally adapted to intensive, intermediate or conventional prolonged treatment schedules, alone or with penicillin, MAPHARSEN is an arsenical of choice in the treatment of syphilis.

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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

The Healthy Hunzas, by J. L. Rodale. (\$2.75. Rodale Press, Emmaus, Pa.) Popular interest in food-health relationships as influenced by the soil in which the food was grown began in this country in 1921, when the great English physician, Sir Robert McCarrison, delivered the Sixth Mellon Lecture at the University of Pittsburgh on "Faulty Food In Relation To Gastro-intestinal Disorders." The salient points of this lecture centered around McCarrison's observation on the marvelous health and robustness of the Hunzas who dwell in a valley on the northwestern border of India where Afghanistan, China, and Russia converge.

These observations were given wider circulation and greater emphasis on the part played by the quality of the soil in food-health relationships by the writings of Sir Albert Howard, a great orthodox agricultural scientist who became convinced from his own work in India that chemical fertilizers in the main only "blew up" the plant at the expense of its health and of its nutritive values, that what we have been getting since the introduction of chemical fertilizers around 1860 has been volume and not value, and that the only kind of fertilization that was safe and health-producing was the composts.

Sir Albert was a close friend of Sir Robert's and of the Lorimers who also had visited the Hunzas. He used all that McCarrison told him to support his own ideas of organic farming. Dr. G. T. Wrench, in 1938, published his book, **The Wheel of Health** about these same people based upon his association with Sir Albert, Sir Robert, and the Lorimers.

The author who is also the author of *Pay Dirt* and editor of the magazine *Organic Gardening* has collected in the meantime additional material in shape of numerous books and articles dealing with northwest India. In addition, he has exchanged many letters with the present ruler, the MIR of Hunza, who is well informed about what is said of his people in the outside world and who writes excellent English.

This book, however, was written to interest the public in a theory of agriculture as it relates to the health of plants and animals who live upon them, including Man. As such, it is one of a dozen which have appeared in the last fifteen years designed to convert the reader to "Organics." This and many of the others have been dressed up with the trappings

of a cult according to ancient formula so well known to the medical historian: "One cause, one remedy, one master, one set of facts set forth in the gospel." This book then becomes a commentary on the "gospel."

Stripped of its mysticism, there is much that is of vital importance in this book to the health of our people. As the population of the world increases 20,000,000 souls each year and more, and the land becomes depleted, the problem facing the world is not so much how to cure disease or even to prevent it as it is to keep our citizens in robust health. Read with a judicial eye and with a mind trained to detect fallacies of cultism, physicians can get many important facts and suggestions from this entertaining book.

Medical Hypnosis, by Lewis R. Wolberg, M.D., Volume II, *The Practice of Hypnotherapy*, (\$6.50. Grune & Stratton, New York City) is an attempt to tell how one combines the skills of hypnotic induction and psychotherapy and coordinates them in the treatment of patients. The conclusions presented in each of the three types—symptom removal, psychobiologic therapy, and psychoanalytic therapy—are based on a wide clinical experience.

American Sexual Behavior and the Kinsey Report, by Morris L. Ernst and David Loth, (\$1.75. The Greystone Press, New York City) extols quite naturally coming from these authors the fact that the book ends the Hush-and-Pretend Era. They point out that he clears the way for a sensible consideration of the problems of sex. Even so, your reviewer wonders how much it will contribute to the pressing problem of population limitation—if this is to be undertaken through contraceptive devices then the white race is doomed.

Handbook of Orthopedic Surgery, by Alfred Rives Shands, M.D., (\$6.00. Third Edition. C. V. Mosby, St. Louis) has been brought up to date with a record of the worth-while developments evolving out of the last World's War. It is certain therefore that this volume will continue to be used as a text in many schools and widely consulted by men in general practice.

Microbiology and Pathology, by Charles F. Carter, M.D., (\$5.00. Fourth Edition. C. V. Mosby, St. Louis) now treats of the sulfonamides and antibiotics. The text still is divided into General Principles of Microbiology; Relation of

Bacteria to Disease; Bacteriology of Milk and Water; Special Bacteriology; Pathology; and Laboratory Exercises. A marvelous compendium in 840 pages.

The Liver and Its Diseases, by H. P. Hims-worth, M.D., (\$5.00. *Harvard University Press, Cambridge, Mass.*) comprises the 1947 Lowell Lectures by the professor of medicine in the University of London. It is most timely that such a review of our knowledge of the diseases of the liver should be undertaken by such a distinguished authority. Everyone interested in internal medicine and especially every student of nutrition should read and study this volume.

Junior Speaks Up, by Irving R. Abrams, M.D., (\$2.50. *Macmillan Co., New York City*) presents a new approach to the subject of the care and behavior of infants and children in that it is taken from the viewpoint of the baby. The script-like presentation gives the book readability. The author, a Chicago pediatrician, has given the parent an immense amount of information in a most effective manner.

Advances in Pediatrics, Volume III, 1948, (\$7.50. *Interscience Press, New York City*) presents eight personalized monographs of contemporary interest. Your reviewer is particularly gratified to note the shift in emphasis from the restoration of health to its protection and promotion. Clement Smith of Boston offers 50 pages on birth injuries; T. L. Terry of Boston also some 16 pages on Retrolental Fibroplasia; Milton Senn of New York some 20 pages on Emotions and Symptoms in Pediatrics; William Lennox nearly 40 pages on the therapeutic agents in the treatment of epileptiform seizures; Joseph Stokes, Jr., of Philadelphia, 20 pages on Viral Hepatitis; Lawson Wilkins of Baltimore, 50 pages on Abnormalities and Variations of Sexual Development During Childhood; Hilde Bruch of New York, 70 pages on Puberty and Adolescence: Psychological Considerations; and Beckett Howorth of New York, nearly 20 pages on The Osteochondroses. The volume certainly lives up to its purpose of keeping physicians informed of recent advances in pediatrics.

Pediatric Nursing, by Gladys S. Benz, R.N., (\$4.00. *C. V. Mosby, St. Louis*) is intended to open the door to a broader understanding of the basic principles of child care and increase the interest of the student in those community agencies and institutions which influence the child. With it goes an excellent teacher's guide for Pediatric Nursing.

The Psychological Origin and Treatment of Enuresis, by Stevenson Smith, Ph.D., (\$1.75. *University of Washington Press, Seattle, Wash.*) is a practical discussion of bed-wetting and the

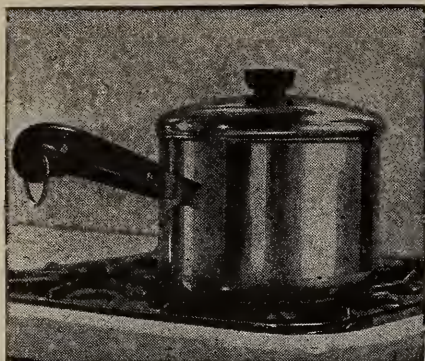
behavior difficulties which so often accompany it. This distressing difficulty is recognized as a warning that the child's world does not give him the security and reassurance which he needs. The author has had ample opportunity to study this problem among the 25,000 children brought to the state clinic.

Medical Care of the Discharged Hospital Patient, by Frode Jensen, M.D., H. G. Weiskotten, M.D., and Margaret A. Thomas, M.A. (\$1.00. *The Commonwealth Fund, New York City*) tells the story of a program at Syracuse University. It was found that, because of proper care in the home, many patients could be discharged earlier and rehospitalization was greatly reduced. The saving in hospital costs was about three times the cost of the experiment and of greater importance was the results to the individual patient. To me it emphasizes the fact that the chronically ill indigent patient is a continuous drain on the community and must be piloted, medically at least, through the rest of his life unless we wish to continue to waste time, effort, and money to little or no avail. Community health agencies should recognize this fact and act accordingly.

The Pathologic Physiology of Uremia in Chronic Bright's Disease, by Stanley B. Bradley, M.D., (\$2.00. *C. C. Thomas, Springfield, Ill.*) is another one of these American Lecture Series of which we need a lot more. Here in some 70 pages worked up into a handsome and handy volume, we have a survey and correlation of the various functional disorders with the clinical manifestations of uremia. The lecture is supported by 128 key references. Every physician who has the responsibility for maintaining normal physiology in these patients who are balanced without buffers upon a knife-edge of security subject to every change from within and from without, must be mindful of the facts set forth by the author lest he kill his patient through neglect or by over-zealous and thoughtless therapy.

The Baby's First Two Years, by Richard M. Smith, M.D., (\$2.75. Revised Edition. *Houghton, Mifflin Company, Boston, Mass.*) has been pretty much rewritten from the viewpoint of the mother who takes care of her own baby. The daily routine has been simplified for the modern mother and the information all brought into line with the latest in medical practice by this distinguished emeritus professor of pediatrics at Harvard.

Diseases Affecting the Vulva, by Elizabeth Hunt, M.D., (\$7.50. *C. V. Mosby, St. Louis*) is the third edition of an English monograph of some 200 pages giving comprehensive treatment to the subject.



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Coma

MARTIN H. FISCHER, M. D.

A standard question asked the medical student of forty years ago was to classify the comas. To make it easy, let me say that no classification is possible. Coma is always just one thing and synonymous with what is an edema of the brain.

DEFINITION AND FACT

Coma is a deeper form of normal sleep. And what might it be? It appears whenever the current of blood through the brain is sufficiently reduced. The question is not silly: Is sleep or the state of awareness (awakeness) the normal of man? The answer is that it is sleep; and that the higher organism does not waken unless prodded. What happens physiologically in man is that the chronic bloodlessness of his brain is relieved for a few hours in each twenty-four to wake him up. More oxygenated blood is pumped into his brain and so the amount of oxidation in it, increased. This is brought about normally by a redistribution of his body's blood. In sleep, blood pools in the belly and to wake up the subject in the morning requires that the impressions of the environment come in upon it—the alarm clock goes off, light enters the window, the air is chill. To these imprints from the outside come several from the inside. Thirst, hunger, and a filled bladder are of the lot. Consequence is a redistribution of the organism's blood through vasomotor activity. Thus more and better oxygenated blood rises into the head. In opposite fashion sleep is induced (1) whenever through psychic or physical accident the blood supply to the brain is lowered and/or (2) when through injury or intoxication of the brain tissues themselves, these are placed in the

The Author

● Dr. Fischer, Cincinnati, Ohio, is a graduate of Rush Medical College, University of Chicago, 1901; and professor of physiology, University of Cincinnati College of Medicine.

position of not being able to utilize such oxygen as does come into them. Directly said, anything which sufficiently reduces oxidation rate in the cerebral tissues acts "anesthetically."

When the carotid and the vertebral arteries of a dog are exposed experimentally and ligatures are laid about them, nothing happens. But with the dog awake, if traction is made upon these ligatures the dog's head droops. This is because the flow of arterial blood into his brain has been reduced—an experimental situation identical with that of the clinical in the cerebrally affected arteriosclerotic. Any anesthetic, whether volatile or fixed, brings about like end. In former instance not enough oxygen enters the brain; in latter, enough enters but cannot be employed.

The difference between normal sleep, a faint, stupor, and coma is one of degree only. Their danger is as the length of the time involved in the episode, this depending upon the relief or the non-relief of the conditions producing them. Every physiological, pathological, or biochemical trick which makes for an inadequate oxygen supply to the brain and/or for its inadequate utilization afterwards, leads to sleep; and, in the extreme, to coma and death.

How mere lack of oxygen in the central nervous system tissues works, has been indicated.

An address to the Staff of Christ Hospital, Cincinnati, February 20, 1943.

How does a soporific, an anesthetic, or (better said) any narcotic produce its effects? These materials soak the entire organism to make its constituent cells incapable of using oxygen even when it is there. In human instance the effects of all these substances is wanted principally in the central nervous system. But a narcotic works "all over." The animal becomes unconscious to peripheral stimuli (not only those of pain but those of touch, heat or cold as well) and goes to sleep. The products of accident and disease work in exactly the same way.

Anoxia in any tissue is followed by both chemical and physical effects. Under first head, acids are produced; under second, the tissues swell. Thus it comes about that when the brain is involved, its functions become distorted and its substance swells. This explains why the coma of the clinic comes out the swollen or "wet" brain of the deadhouse.

There is only one cause of edema and that is the presence in the tissues of something which increases their capacity to hold water. This is a matter of the hydratability of the colloid materials they contain, especially that of the proteins. A bit of acid added to the brain substance enormously staggers its capacity to absorb more water.

Edema of the brain is never the product of an increased intracranial blood pressure. Such is supposed to be capable of pushing more water into it. Actually the brain substance first suffers chemical changes which make it suck water into itself from any available source. If this is not clear to you, let me give you an illustration. A slice of brain laid into a 1/10,000 normal lactic acid solution more than trebles its weight in 24 hours—in other words, it absorbs over 200 per cent of its own weight in water. This edema obviously, can have nothing to do in its origin with an increased blood pressure for there isn't present any pressure at all! In this experiment the acid of the solution ties itself to the brain substance, the resulting compound being a colloid mass able to absorb more water. (This experiment has been criticized by saying that "enormous" quantities of acid were employed, which is nonsense. A 1/10,000 normal acid is so weak that it cannot be tasted as an acid; so weak too that it does **not even** approach the concentration of the acid produced in disease or post mortem.) And just what percentage of swelling of the brain must be accounted for to explain the clinical signs incident to coma—a 5 per cent swelling is followed by stupor and an 8 per cent by death.

THE QUESTION OF ALKALOSIS

Poisoning by acid as a cause of brain edema suggests at once the use of alkalies to combat it. But should "alkalosis" not be feared? It

never comes to pass in practice. Over-alkalinization of a patient is impossible because the normal chemistry of his body is such that enough carbonic acid alone is produced in each 24 hours to neutralize two pounds of caustic soda—and no therapist is likely to administer that amount of "alkali" to anybody. To what then might the symptoms allegedly due to poisoning with alkalies as seen in the clinic really be referred? They are the product of poisoning by light metal bases. Sodium, potassium, and ammonium as substituted for the bases normally present in protoplasm increase its water-holding capacity; physiologically they increase its "irritability." Affecting the nervous tissues, consequence may be a "tetany." This however, is not due to over-alkalinization but to the type of salts used to produce the alkalinization. Substitute the salts of calcium or magnesium for those of the lighter metals (the too much of baking soda, for example) and there is no tetany.

If all the comas are the same, it is obvious that they can differ from each other only in the mechanisms through which they are induced. Let the coma incident (1) to trauma of the brain, (2) its intoxication, (3) that appearing in association with the nephritides be taken up in this order.

COMA DUE TO TRAUMA

The coma following injury to the head has beginning in the resultant anoxia. Gross injury to the arteries of the brain may bring this about but such injury with hemorrhage by rhesis is not the pathology found in most of those patients who after an automobile accident say, walk into the hospital. They may be dazed but they are awake. In the course of the next hours however, they fall asleep, then into coma and in the hours or days afterwards, die. On the necropsy table these victims may evidence no gross injury to the blood vessels. Their brains however are swollen and their convolutions flattened. If puncture was made before death, the spinal fluid issued forth under increased pressure. The accident jarred the brain (its mayonnaise-like structure was shaken up). And it was this mechanical injury which affected the oxidation rate of the brain tissues leading to the production and accumulation of acids in them and so to their swelling.

As already noted, it requires but few per cent increase in water absorption by the brain to bring about the death of the subject. As the brain swells it presses upon and tends to obliterate its capillary circulation—the situation therefore tends to make itself worse unless help is given from the outside. It is this fact that underlies the good effects of trepanation, subthecal or spinal puncture. The brain is of those organs which cannot swell much before

encountering a non-expansile housing. The removal of the cerebrospinal fluid or the making of an opening into the cranium thus becomes at times a life-saving measure in that it enlarges the space into which the brain may swell.

COMA DUE TO INTOXICATION

The coma secondary to any type of generalized intoxication (write in the name of any of the volatile or fixed anesthetics, that of the toxine of any of the infectious diseases, that of the several therapeutic or industrial poisons) is well illustrated in diabetes mellitus. Physiologically defined, diabetes presents a state in which the normal oxidation of all the carbohydrates and the fats, and the one-half of the protein to carbonic acid, is interfered with. Physiologists have long said that fat burns to carbonic acid only in the fire of carbohydrate. This fire burns too low in diabetes wherefore the fats are not burned to carbonic acid but only to the half-way, clinker stage represented by the appearance of acetone, beta-hydroxybutyric and acetoacetic acids. Of the lot, the two last are acids while acetone is by itself an anesthetic. The combination poisons the brain of the subject both directly and indirectly. It reduces him to coma even as it makes his central nervous system swell. Because of the situation, many diabetics die in coma.

Much has been made of this acidosis, coma and death as apparent in the diabetic. Yet he constitutes only a fraction of those who die of this type of poisoning and without ever having shown sugar in their urines. Frankest picture comes to view in starvation, be it this either in the terms of quantity or of quality. Straight-out lack of food or an obstructive esophageal cancer which prevents the taking of food illustrates the first; as does the inadequate consumption of food by the protracted fevered. Vitamine lack illustrates the second. But such circumstance kills equally well those who are sent into hospital to be "prepared" for operation. This residence more commonly prepares them for the undertaker because they are made subject to the inadequacies of the "standard," "light" or "hospital" diet. On them they develop an acidosis, starvation edema, and in the end, that sleepiness which may prove fatal. The surgeons have long found these specimens bad risks, for standing already on the brink, they may tomorrow be pushed into the abyss when to their present load is added that of the acidosis incident to anesthesia and the trauma of an operation. All of which gives reason to the mandate that patients should be fed up to the last hours before an operation and as soon as possible thereafter.

Practical statement has it that man in protracted starvation runs out of sugar first, then

his fat, last his protein. Actually he suffers from protein lack first. But since protein is the substance of his whole machinery he does not commonly register this fact until he dies of it. This is why the "support" of a patient requires first that he be fed protein (and to get the whole of the story, the nitrogen-containing vitamins of the B class); thereafter, and in this order, carbohydrate and fat. These principles of proper nutrition were common knowledge in the first World War even though they were little employed. They were better used in the second World War but too largely empirically and without proper understanding of why.

First reason for the intravenous infusion of blood or of blood plasma lies in the fact that as liquid and hydrated colloids they help to maintain blood volume (salt and sugar waters are lost from the blood within two hours after their injection). In this way blood or plasma infusions mitigate the effects of vascular "shock." But also, they feed. It is on this account that (in the non-shocked) the "hydrolysates" of protein act quite as well. But the feeding of protein as of any other food is of little use unless employed in adequate amount. The daily protein requirement of man is 125 grammes. This quantity is not put into him by a cup of hot bouillon!

Adequate caloric coverage lies in the parenteral or enteral administration of the sugars, particularly dextrose. But here, too, the amounts commonly purveyed per day fall far below the needed. To yield the low of 1600 calories requires the uptake of 400 grammes of carbohydrate! No scheme exists whereby fats (to raise the caloric intake) can be injected parenterally. To get them into the body of the subject requires their alimentary administration. These items therefore sum up to the following: Parenteral schemes for the administration of food are rarely adequate because insufficient in amount; the oral route must be placed back in function as quickly and as effectively as possible. Every patient needs to be fed not only up to the level of what are his food demands for each day when merely at rest in bed, but in twice such amount if previously starved, fevered, or in the preoperative or post-operative phase of his existence. Ardent alkalization helps (use chalk!) because whatever the cause of an acidosis its products are the same. But neither for the directly starved patient nor for him starved indirectly as in diabetes is mere alkalization enough; the causal pathological mechanism must be adjusted.

COMA DUE TO POISONING BY METALS

Coma appears as the accompaniment of various types of metal poisoning. Death from arsenic

injection of "606" and like derivatives of arsenic for malaria and syphilis brought about identical picture under what might be called laboratory conditions. Workers in lead commonly developed peripheral neuritides but some of them "went crazy" besides. When the anti-knock compound, tetraethyl lead, was discovered, the first handlers of this material (not the distributing agents but the discoverers thereof in the laboratory!) not only developed blue lines of the gums, foot-and wrist-drop, but went "loony." Hence the reference to gasoline treated with tetraethyl lead as "loony gas." These materials—to which several more of the elements in the periodic table might be added—act in the human frame as do the anesthetics. They cut down the oxidation rate of all living cells. When the substance of the brain becomes involved, the victim may develop both mental or motor signs before he sinks into the too deep sleep of coma. The sequence is as already detailed. Arsenic, lead and like metal intoxicants lead to an edema of the brain, the manifestations of which are like those of delirium tremens.

The surgeon is not often confronted with what is the coma which draws the curtain on the man dying of heart disease. This picture, however, is also of the simple pattern already described. As a heart weakens, progressively greater anoxia and so the accumulation of its by-products in the peripheral tissues follows. In heart disease, the business begins in the feet, for these lie farthest from the cardiac pump. They swell. Draw a series of concentric circles about the heart as centre and observe how with increasing cardiac decompensation the head becomes involved. As this happens the patient begins to sleep too well and too long. One morning he cannot be awakened even by loud talk. His respiration alters and in time he stops breathing. The edema that began in the feet and ascended, became the edema that involved his brain and descended. If death did not arrive at this level then the lung may have been reached to close a life's show in pulmonary edema.

COMA COINCIDENT WITH NEPHRITIS

Coma appears in conjunction with nephritis, never as its consequence. The way this is said should be noted. This is the coma alleged to be the consequence of a "uremia," dependent upon the kidneys' failure to rid the blood, and so the total organism, of its excrementitious products.

The ablation of both kidneys is followed by an increase in the concentration of the urinary constituents in the blood and so in all the tissues. This is a true "urine in the blood." But death from this cause does not carry with it

the signs and symptoms which in the clinic are alleged to be consequent upon uremia—the animal develops no generalized edema, no increase in blood pressure and does not die in coma with or without convulsions.

How then must the coma appearing (1) in association with parenchymatous nephritis, (2) in association with chronic interstitial nephritis (nephrosis, Bright's disease) be interpreted?

In the first instance the edema of the brain is identical with what is the edema of the kidneys. Both are due to a common cause; whatever the intoxicant, it has struck both the brain and the kidneys. Coincident with edema of the kidneys goes a suppression of urinary output, albuminuria and casts; coincident with the similar edema of the brain appear stupor, convulsions, coma, and death.

In the second instance it requires that what is the cause of the chronic interstitial nephritis be seen to have its counterpart in the brain. This (now-called) nephrosis is the consequence of blood vessel disease (well-dubbed by Gull and Sutton, arterio-capillary-venous-sclerosis). In its effects it is not however limited to the kidneys but is common to all the organs of the body. Its effect is to obliterate section after section of the kidney, even as it obliterates in similar fashion, section after section of the brain. As long as small areas only in either organ are struck, enough life-saving tissue remains over to continue the allegedly normal life of the organism. (The victim suffers no urinary lack even though he may dodder and grow simple.)

Vascular disease sufficient to interfere with the total of the blood supply to the kidney rarely comes about. Such is commoner in the case of the brain where occlusion brings larger sections of the total organ into a state of anoxia. When this situation develops the patient tends to sleep and, in persistent case, falls into coma and death. This picture is also called that of the "uremic" but it is really only that of brain edema over again—the effects of straight-out lack of oxygen are followed by the accumulation of acidosis products in the brain itself to lift its capacity to swell to unrecoverable-from level and so death.

The head symptoms in parenchymatous nephritis depend upon an edema of the brain identical with that present in the kidney and both are of identical toxic origin. In chronic interstitial nephritis it is vascular disease that is common to both. "Atherosclerosis" is a disease claimed to be of unknown etiology and impossible of relief, wherefore prognosis in first instance may

sometimes be good but in latter, uniformly written down as bad.

THE SYMPTOMS AND SIGNS ASSOCIATED WITH COMA

A generalized swelling of the brain substance easily explains why a headache. It is the characteristic of any kind of generalized intoxication, lie its origin in alcoholism, another anesthetic, or the poison of an infectious disease. This explains too the stupor which the physician may see or of which the patient may complain. Edema of the brain explains also the coincident mental and/or motor disturbances. Mania or convulsion involves the highest lying regions of the cranial tissues. Their edema as it spreads downwards is followed by nausea, vomiting, and respiratory disturbances.

The changes in blood pressure frequently recognizable in the cerebrally affected require extra thought. Only two factors are known which lead to increase in the measurable peripheral blood pressure: (1) Increased intracranial pressure, (2) increased stiffness of the blood vessel walls to compression. The first appears as aftermath to any kind of brain swelling (be it induced of any kind of intoxicant, an infection or the toxemia incident to eclampsia); the second, as consequence of a physiological or pathological "hardening" of the blood vessel walls.

THE TREATMENT OF COMA

Coma is a piece of every man's practice. So is its treatment. To know what should and can be done, and to know thereafter how much towards cure may thereby be accomplished, begin in proper diagnosis. An edema of the brain which follows upon a sudden injury is one thing; that which is the result of a progressive arteriosclerosis, quite another. The purpose of treatment is the same in both but the accomplishable something distinct. Prognosis depends upon what is the removability of a first cause.

In practical terms how may an established brain edema be reduced? This can be accomplished over two routes only: More room may be provided for the swelling mass; the tendency of the brain to swell may be countered. Trephine, subthecal or spinal puncture aids the former; alkalies, salts and sugar the latter.

Advice as to care for the comatose sums up to this. In the acute case, as after injury on the road, the patient is served best if nothing is done to him. To jerk him into upright position, transfer him to an ambulance, rush him to hospital and then skate him around for X-ray photography is just to add to the features of his brain swelling. In milder circumstance the provision of an increased amount of space into which his cerebrospinal tissues may swell may be gained by spinal puncture, etc. Such may prove life-saving. From internal side his

cerebrospinal tissues need dehydration. The two elements best fitted to this end are (1) alkalies, (2) salts (including sodium chloride). Practical experience reduces their employment to two—alkalinize with sodium bicarbonate by mouth, rectum, or intravenously; ply the subject with magnesium sulphate.

These principles of treatment apply even when the brain edema has behind it chronic cause. I have seen the comatose in vascular disease awakened after an ounce of saturated Epsom salts had been injected into their stomachs; a grain or two of calomel had been administered, etc. Time may cure the acutely afflicted; but it does less when cause is more persistent in type. Coma lies between these two extremes.

Factors in the Development and Growth of Children's Personalities

The first point of view may be referred to as the autocratic or environmental. This approach assumes that we have an adequate culture in which we can fit our children, that the child should be treated more or less as a lump of clay to be molded according to the circumstances and dictates of his environment. I do not accept the premises underlying that standpoint. I do not believe that we have, at present, the culture that can bring out the best in the development of the child, and since we do not have the best of cultures, we naturally should not impose in toto the present culture upon the growing personalities of our children.

The second point of view may be entitled laissez faire which assumes that the inborn inherent factors are fully capable of their own development, with a minimum of interference from the environment. This viewpoint, I believe, lies behind many of our progressive systems of education which believe in allowing the child to express himself on any and all occasions.

The third approach with which I am quite sympathetic is called the developmental, which does not stress the environment at the expense of the individual or vice versa. This viewpoint emphasizes the relationship which exists between the growing child and his environment of persons and things. In stressing this relationship, one likes to think of it as a vital, spontaneous, dynamic one.

For the maintenance of such a culture, we require parents, teachers, etc., who can enter into the basic relationship of taking and giving with pleasure and who will develop their children to give with pleasure and satisfaction. When that has been achieved then we shall have mature adults, and then this means that the affairs of the world will be conducted along adult lines.—Charles C. Graves, M. D., Des Moines, Iowa. The Journal of the Iowa State Medical Society, Vol. XXXVIII, No. 10, October, 1948.

A Case of Amebic Lung Abscess Treated with Emetine

HERMAN S. APPLEBAUM, M. D., and JEROME S. FRANKEL, M. D.

UNTIL relatively recently amebiasis was considered to be a tropical disease. That this opinion was erroneous was emphasized in the recent epidemics of amebic dysentery in this country.^{1, 2, 3} According to Craig⁴ ten per cent of the people of this country harbor the *Endamoeba histolytica*. Amebiasis was frequently overlooked because of the mildness of the clinical manifestations.

Amebiasis has become more significant as a disease in non-tropical countries with the return of several million veterans from heavily infested regions. Most if not all amebic infections begin in the large bowel. From this area the amebae are carried through the blood stream to other parts. The liver is involved most frequently because the portal circulation drains the gastrointestinal tract. The extension of the amebic abscess of the liver may result in abscesses elsewhere. This is probably the mode by which most of the pulmonary abscesses develop. Occasionally it may be secondary to a focus elsewhere, but rarely if ever does primary abscess of the lungs occur.^{5, 6}

The surgeon must become more conscious of this disease because amebiasis may simulate the clinical picture of cholecystitis, pancreatitis and appendicitis. The high incidence of hepatic and less frequent pulmonary complications are also important surgically. Ill-advised surgical intervention in misdiagnosed amebiasis may lead to disastrous results. Drainage of hepatic and pulmonary abscesses without previous chemotherapy has a very high mortality rate. Ochsner⁵ considers pleuropulmonary amebic infection second to hepatic lesions as a complication of amebic dysentery.

Ochsner⁵ classifies pulmonary infections due to ameba into five groups: 1. Hematogenous pulmonary abscess without liver involvement. 2. Hematogenous pulmonary abscess and independent liver abscess. 3. Pulmonary abscess extending from the liver abscess. 4. Broncho-hepatic fistula with little pulmonary involvement. 5. Empyema extending from the liver abscess.

The diagnosis of amebic pulmonary abscess is often difficult to make. It is suggested if liver involvement by ameba is known to have been present previously, or if amebic dysentery was once present. The clinical manifestations of pulmonary abscess consist of cough, expectora-

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tion of large amounts of sputum ("anchovy paste"), fever, enlarged, tender liver, pain in the chest, and cachexia. The roentgen ray examination of the chest is usually of great value in establishing a diagnosis because of the characteristic appearance of the lesion in the right chest. These findings are:⁶ (1) Elevation, fixation and local bulging of the diaphragm; (2) obliteration of the cardio-hepatic angle in the P-A view; (3) obliteration of the anterior costo-phrenic angle in the lateral view. Together with a good clinical history, the diagnosis often may be confirmed. Klatzkin⁷ claims that the diagnosis of pulmonary abscess due to ameba usually rests on the clear-cut specific response to emetine therapy. Others^{8, 9, 10} also have emphasized the diagnostic value of a therapeutic trial of emetine. More direct confirmation requires the demonstration of the ameba in the sputum.

We wish to present a case in which a positive diagnosis of amebic pulmonary abscess could not be made, but complete resolution of the abscess occurred almost immediately following the administration of emetine after other treatments failed.

CASE REPORT

A twenty-three year old white male was admitted to the hospital because of fever of six weeks' duration. The patient was a veteran who had served with the Navy in the Southwest Pacific, New Guinea, and the Philippines. His illness dated back to January, 1944, when he had an attack of diarrhea for one week when he first landed in New Guinea. In July, 1945, the patient had high fever, tenderness in the right upper quadrant of the abdomen, but no diarrhea, nausea, or vomiting. There was no change in the color of the stools or urine. The patient was hospitalized for about three weeks, treated with penicillin and atabrine. The blood smears were consistently negative for malaria organisms. No jaundice developed, and after a short stay

Submitted January 6, 1948.

in the hospital, the patient was discharged as improved.

For six weeks after discharge from the Navy hospital, the patient felt well. He then again developed right upper quadrant pain and fever. He was sent to the hospital and this time stayed for four weeks. There was no associated jaundice, no nausea, vomiting, or diarrhea. There was no change in the color of the stools or urine. The patient was again treated with penicillin and atabrine and discharged as improved. He was discharged from the service in February, 1946, as physically fit but receiving partial compensation for malaria.

In February, 1946, two days after arriving home, the patient had a third attack of right upper quadrant pain and fever. The fever had been maintained until the present admission to this hospital on April 20, 1946. The right upper quadrant pain, however, had abated. In the last month prior to admission, the patient developed pain in the right shoulder which was made worse on coughing. The pain was also more severe when lying on the right side. The pain in the right shoulder was not constant. In the past few days prior to admission the patient developed a productive cough with large amounts of sputum having a foul taste. There had been a weight loss of thirty pounds since the onset of the illness in 1945.

EXAMINATION

Physical examination on admission revealed a well developed but very poorly nourished white male appearing acutely ill. He was dyspneic but not orthopneic. The cough was annoying and persisted throughout the examination. The patient appeared to be more comfortable leaning towards the left side. Examination of the lungs showed no change to percussion, some diminution of the breath sounds at the right base, and scattered rales in this region. The blood pressure was 102/58, there was normal sinus rhythm, a pulse-rate of 100, and no murmurs. There was spasm on palpation of the entire abdomen. The liver was not palpable. The spleen was palpable and tender. The reflexes were physiological.

The admission white cell count was 17,400. 89 per cent polymorphonuclear cells, 9 per cent lymphocytes, 1 per cent monocyte, and 1 per cent eosinophile. The red cell count was 3.76 million with 71 per cent hemoglobin. Repeated blood counts showed a variation between 6,000 to 10,000 white cells and normal hemograms. The red cell count remained around 3.5 million. The urine on admission was within normal limits. Blood chemistry studies showed no abnormalities. The icterus index was 4, the Van den Bergh was less than 0.5 units. The total proteins were 7.3 grams per cent: albumin 3.5 and globulin 3.8. Blood agglutinations for typhoid, paratyphoid, and dysentery organisms were consistently negative. Agglutinations for tularemia and undulant fever were also negative. Repeated examinations of the blood for malaria organisms failed to reveal any parasites. Numerous examinations of the sputum for ameba or other parasites were consistently negative. Daily and collected twenty-four hour sputum examinations failed to reveal amebae.

HOSPITAL COURSE

The course in the hospital was stormy. Following admission an X-ray of the chest revealed the left diaphragm to be normal in position and clearly delineated. The right appeared

slightly elevated. Both costophrenic sinuses were clear. In the cardiophrenic angle on the right a round area of homogenous density could be seen in which an area of rarefaction and a fluid level were visible. Lateral view showed the cavity with the fluid level situated posteriorly at the level of the ninth and tenth thoracic vertebrae. The fluid level was just anterior to the vertebral bodies. This was interpreted as a lung abscess. The patient was placed on large doses of penicillin but in spite of it had repeated exacerbations of pain in the right shoulder and in the right upper quadrant of the abdomen, associated with hemoptysis and production of large amounts of sputum, and fever. The large amount of sputum produced was probably more than a relatively small abscess cavity could hold. Postural drainage at first seemed to help the elimination of the sputum, but soon had to be discarded because of the discomfort it produced. The temperature was of the intermittent type, and spikes often reaching 105 degrees F. were obtained. After five days of penicillin the temperature dropped to 100 degrees F., and remained at this level for approximately four days.

A flat film of the abdomen taken on the second hospital day revealed a prominent splenic shadow. An X-ray of the chest on the ninth hospital day revealed that the amount of infiltration surrounding the abscess cavity in the right lower lobe was diminished. The cavity itself was very clearly seen in the lateral view. On the tenth hospital day, the fever again began to spike, levels of 102 degrees and 103 degrees F. being reached daily. Two whole blood transfusions were given as supportive therapy. The patient was started on penicillin aerosol on the twelfth hospital day, and because no apparent improvement resulted, all penicillin therapy was stopped on the twentieth hospital day. An X-ray taken on the nineteenth hospital day showed no change in the degree of infiltration in the right pericardial region. On the twenty-first hospital day, the patient was started on sulfadiazine and maintained on this drug until the twenty-sixth day without any improvement.

Because of the lack of improvement, bronchoscopy was attempted in order to aspirate the abscess cavity. Aspiration yielded a considerable amount of bloody purulent material from the right lower lobe bronchus. No tumor or constriction was noted. Bronchography following bronchoscopy showed good visualization of portions of the right upper and middle lobe bronchial tree. The lower lobe was incompletely filled. The lateral and anterior branches were filled and were normal except that they were somewhat compressed together and displaced slightly upwards. The medial branch was incompletely filled and the posterior branch was filled only in its proximal portion. The area of infiltration of the medial portion of the right base was now much larger than on the previous examination, and it was along the border of this infiltration that the bronchi which were filled were seen to be compressed and displaced. No abscess cavity was visible in contradistinction to the previous films.

Because of the absence of a response to penicillin and sulfadiazine, and because the patient's condition was gradually deteriorating, a trial with emetine was decided upon in spite of our inability to make a positive diagnosis of amebic lung abscess. All medications were, therefore, discontinued on the twenty-sixth hospital day, and eme-

tine hydrochloride, 0.06 grams, was given intramuscularly once daily. Three days after emetine was started, the temperature was normal for the first time since admission. X-ray of the chest two days prior to discharge showed almost complete resolution of the infiltration at the right base. The right leaf of the diaphragm was seen clearly in the lateral view. Just above the midportion of the right leaf of the diaphragm in the lateral view some areas of radiolucence could be seen. This probably represented an area of focal emphysema, possibly the result of lung necrosis. The temperature continued at a normal level and the patient was discharged on the thirty-sixth hospital day after ten injections of emetine.

A barium enema visualized the entire colon. The colon was normal and there was no spasm in the cecal area. A film of the chest approximately one month after discharge showed the area previously involved to be entirely clear. There was no longer any evidence of abscess formation or areas of diminished density seen at the last examination. The interlobar septum was less thickened than before. This was essentially a normal chest.

DISCUSSION

Although amebae were never found in the stools or sputum of this patient on repeated examinations, we believe that this patient had an amebic abscess of the lung. That the abscess was not primary in the lung is also fairly certain. The history of diarrhea, and the subsequent attacks of right upper quadrant pain lead one to suspect amebiasis of the liver with extension to the right lung. This impression is further supported by the fact that during his hospital stay when exacerbations occurred in the lung as represented by high fever, marked increase in cough, and increase in the quantity of sputum which was often hemorrhagic, they were also associated with pain and tenderness in the right upper quadrant. The amount of sputum, which often measured 1000 cc. per day, could not have come from a relatively small abscess in the lung, but must have been fed by another focus. While amebiasis was considered a possibility, we had no evidence of the patient's having amebic dysentery when in New Guinea; and with our failure to find ameba in the stool or sputum after intensive search, we were inclined to try therapy with penicillin and sulfadiazine before emetine. However, because of the remarkable response to emetine therapy in this case, we feel that in any obscure lung abscess in which the history is suggestive of amebiasis, even though not definitely proven, a therapeutic trial with emetine is indicated.

SUMMARY

1. A case of suspected amebic lung abscess is presented.
2. Treatment with penicillin and sulfadiazine failed to produce a therapeutic response.
3. A rapid response in the clearing of the

abscess was obtained with the intramuscular use of emetine hydrochloride 0.06 grams daily for ten days.

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Case-Finding

Recently it has been recognized that general hospitals and clinics normally operate as concentrating mechanisms for cases of tuberculosis. Less consideration has been given the offices of the general medical practitioners. A pilot study by Dr. Albert C. Daniels, then in private practice in California, suggests that an alert general practitioner can contribute measurably to the solution of the tuberculosis problem in his community. While the figures are small they are nonetheless suggestive. Between October, 1941, and April, 1942, Doctor Daniels routinely fluoroscoped 250 patients. This included all new patients who passed through his office during this period. Films were taken of all patients who showed suspicious findings on fluoroscopy. Seven active cases of pulmonary tuberculosis were discovered in this group of 250 patients, a prevalence of 2.8 per cent. They varied in age from 18 to 57. None gave a history of close contact. Only one suspected that he might have tuberculosis; only one had physical signs suggestive of pulmonary disease.

A serious weakness in many case-finding techniques has been their inclusion of such a large part of the healthy segment of the population. Preliminary figures derived from 350,000 miniature films taken in California during the past year reveal a prevalence of only half of one per cent or about one-sixth of the Daniels figure. A further weakness is the periodicity of these techniques. Hospitals, clinics, and physicians' offices furnish a constantly functioning service that should not be neglected.—*Case-Finding, Sidney J. Shipman, M.D., Editorial, The American Review of Tuberculosis, December, 1947.*

The Brown Modification of the Wiltberger-Miller Pregnancy Test

ANSON L. BROWN, M. D.

DURING the last few months we have been experimenting with the latest pregnancy test, namely that one which has been recently described by Dr. P. W. Wiltberger and Dr. David Miller. In their test urine is injected directly into the frog. In the Brown modification the urine has been concentrated and instead of a five cubic centimeter portion of urine a concentrate representing at least forty-five cubic centimeters of the specimen are used.

TECHNIQUE OF THE TEST

1. Into a 50 cc. graduated cylinder pipette two drops of Brom Cresol Purple. (This is a 0.5 per cent aqueous solution of the indicator.)
2. Add the urine specimen up to the 45 cc. mark. If less than this amount is available dilute with water to the 45 cc. mark.
3. Invert to mix the indicator and the urine specimen.
4. Add 0.5 cc. of 20 per cent hydrochloric acid. At this point the color will be yellow, thus showing that the solution is acid.
5. Add five cubic centimeters of a 20 per cent suspension of kaolin.
6. Mix thoroughly by inversion.
7. Pour the content of the cylinder into 100 cc. bottles (round) and shake on the Kahn shaker for 20-30 minutes.
8. Remove and pour the contents of the bottle back into the original graduated cylinder.
9. Allow the mixture to stand for one hour or until all the kaolin has settled to the bottom. This usually has occurred when the sediment reaches the 5.0 cc. mark.
10. Decant off the supernatant liquid. This liquid is then discarded. In the sediment there is the kaolin together with the chorionic gonadotrophin hormone. The latter must be saved.
11. The mixture is then stirred with an applicator and transferred to a small test tube.
12. The tube is then centrifugalized for 5 minutes.
13. At the end of this time the supernatant liquid is poured off and discarded.
14. To the more or less dried kaolin mass add 2.0 cc. of N/10 sodium hydroxide solution.
14. With a glass stirring rod break up this mass and transfer to a small test tube.
15. Centrifuge for twenty minutes.
16. This time the supernatant liquid is to be saved. Therefore, be careful with it. It should be carefully poured into another small test tube.

The Author

● Dr. Brown, Columbus, Ohio, is a graduate of Ohio State University College of Medicine, 1927; member, American Chemical Society, American Society of Bacteriologists, and Mississippi Valley Medical Society.

17. In this tube at the present time is the hormone in an alkaline solution. Now add about two drops of a 5 per cent solution of hydrochloric acid. This is done to make the solution about neutral or slightly acid. Nitrazine paper is used as the outside indicator. The ph at this point should be between 5 and 6.

18. Now there are about 2.0 cc. of the concentrate and the next step is the injection of this liquid into the frog.

INJECTION OF THE FROG

1. You will note that the skin on the back of the frog is very loose.
2. Place the 2 cc. of the concentrate into a 2½ cc. syringe, to which has been attached a 26 gauged one-half inch needle.
3. With the frog's hind legs held with the left hand very carefully insert the needle just under the loose skin of the frog's back.
4. After injection place the frog into a clean dry 250 cc. beaker. Cover the latter with wire gauze or with some heavy object.
5. Allow the frog to remain undisturbed for one hour.
6. After the one-hour period pick up the animal without bringing it entirely out of the beaker. By this technique the frog will urinate and all of the urine will be collected in the beaker.
7. After urination, a medicine dropper or pipette is used to remove the specimen of urine.
8. We use either a microscopic slide or a concavity slide which will hold twelve urines at one time.
9. Next examine the urine under low power of the microscope. Use a 10 X eyepiece with a 10 X objective.
10. By the concentration method there will be literally thousands of sperm cells when a positive test is obtained. In a negative test there will not be a single sperm cell. There may be a few red or white cells present as

well as any number of parasites which are a common habitat of the frog.

11. Report the test as negative or positive.

SUMMARY OF THE BROWN MODIFICATION

It has been the experience of the writer that:—

1. The Wiltberger-Miller pregnancy test upon the American male frog is an excellent test.

2. Excellent results have been obtained in this laboratory with a comparison of this test and with the Weisman African female frog test.

3. To increase the efficiency of this test the writer has concentrated the urine and instead of injecting a 5.0 cc. portion as suggested by Wiltberger-Miller, we are now able to increase the amount to nine times or around 45 cc. of a sample.

4. It must be remembered that adult male American frogs are now used in this test.

5. This laboratory is now working upon a new method so that blood may be used in place of urine.

Clinical Consideration of the Erythrocytic Sedimentation Rate

In rheumatic fever the erythrocytic sedimentation rate is elevated and it gradually returns to normal over a period of weeks or even months as the active process subsides. In 140 patients under observation in our Rheumatic Fever Clinic and considered to be in the acute phase of this disease, the average sedimentation rate was 20.8 mm./hr. One-hundred-and-forty-six patients in whom the rheumatic process had become quiescent showed an average rate of 7.6 mm/hr.

The erythrocytic sedimentation rate may be of aid in the evaluation of vague muscle and joint pains, commonly called "growing pains," or other equivocal symptoms of rheumatic fever in children. Systolic murmurs are frequently heard in the routine examination of children who are apparently well. Such murmurs may not be significant, but they deserve further consideration. In these cases an elevated sedimentation rate for which no other explanation is apparent suggests the possibility of rheumatic fever and indicates that the patient should have continued observation and examinations.

In severe cases of rheumatic fever, it has been observed that with the onset of congestive heart failure the previously elevated sedimentation rate tends to decrease to levels which would, in other circumstances, be considered normal. This decrease in sedimentation rate may precede obvious signs of failure and serve to warn the clinician of an impending cardiac break. If the heart failure is overcome, the sedimentation rate again rises to its former elevated level.—M. W. Beach, M. D., Clyde D. Conrad, M. D., Charleston; and John R. Harvin, M. D., Sumter, So. Carolina. *Jrn. of the South Carolian Med. Assn.*, Vol. XLIV, No. 9, September, 1948

KEEPING UP WITH MEDICINE

• THEY say that the eruptions following injections of streptomycin may be pruritic, erythematous, or maculopapular, and appear within the first ten days of therapy. The pruritus is usually relieved by antihistaminic. The eruption clears in from three to seven days. Hence, the treatment does not have to be interrupted.

* * *

• THE average hypertensive patient can tolerate 200 mgm. of sodium daily. The loss of sodium from skin and feces even in the absence of perspiration amounts to 200 mgm. So, with a diet containing 200 mgm. of sodium and with urine entirely free of sodium due to complete reabsorption of it, no increase in body sodium can occur.

* * *

• MOORE of St. Louis believes that the incidence of cancer of the prostate in men over 50 is something like 18 per cent—or roughly, the chances for a man over 50 years of age of dying of cancer of the prostate is one in five.

* * *

• ANY change in the bowel habits in an adult is presumptive evidence of cancer of the colon until another diagnosis has been formally established and cancer ruled out by adequate examination.

* * *

• AS a part of the prevention of serum hepatitis, it is unwise to use blood from donors who have a history of hepatitis or anything resembling it during the previous six months.

* * *

• AT present the most important application of clinical electro-encephalography has to do with the diagnosis of conditions that give rise to transitory disturbances in consciousness.

* * *

• WE should remember that as little as twenty grams of acetylsalicylic acid taken orally have been demonstrated repeatedly to produce albuminuria in man and in experimental animals.

* * *

• ONE of the trends in prescribing of milk formulas for babies is the reduction and early elimination of the carbohydrate added to the formula. McCulloch even advises against ever adding sugar in any form to the formula. He claims that under this regime the children develop better, are not so fat, stand hot weather better, and are more active.—J.F.

Medicine and the Changing Order—Industrial Medicine

WILLIAM F. ASHE, M.D.

I am a neophyte in industrial medicine and rather than limit myself completely to my own opinions, I will borrow freely from the ideas and words of others to bring to you a concept of industrial medicine in the changing order in which I have come to believe wholeheartedly. To Drs. Kehoe, Johnstone, Hazlett, and many other leaders in this field, I am deeply indebted.

In an effort to learn the opinions of my colleagues, I have asked this question of about 100 doctors in 16 cities in the last year: "What is industrial medicine?" These doctors were internists, pediatricians, deans of medical schools, surgeons, investigators, general practitioners, public health officers, and men who practice industrial medicine. I received just about 100 different answers, only a very few of which approach a satisfactory answer. Most of us seem to look upon industrial medicine as that aspect of diagnostic and therapeutic medicine which a wide variety of physicians practice when cases arising in industry are referred to them through various channels. Apparently this impression was much more widespread in 1940 than it is now. During the war years, industrial medicine expanded greatly and a great many physicians with no previous experience in it became familiar with some aspects of it. Some of them were greatly surprised, for certainly not all the aspects of a comprehensive program of industrial medicine can be considered as medicine in the traditional sense of the word. Today industrial medicine is assuming a prominence equal to any other phase of medicine, and a broader type of medical practice can be expected to develop under its influence. But before scanning future horizons, let us define industrial medicine and look for a moment at its early history.

Industrial medicine in the United States (its meaning is broader in more socialized countries) is medicine in industry. It is an integral part of industry. It is a service. The main purposes of the industrial medical service have been defined by Dr. Kehoe as follows:

1. To promote the health of industrial workers.
2. To reduce the economic losses of wage earners and employers occasioned by physical inefficiency, sickness, and injury.
3. To study the basic environmental condi-

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The Author

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tions of industrial employment and the reactions of workmen thereto so as to reduce occupational handicaps and hazards and to place individual workmen in the most suitable jobs.

INDUSTRIAL MEDICINE IS PREVENTIVE

If one word in our medical vocabulary were to be used to describe industrial medicine, it would not be treatment as is so commonly supposed but rather it would be prevention.

Contrary to common belief, industrial medicine is not young, for it had its inception in antiquity. To indicate its age, it is sufficient to mention only a few of the physicians in olden times who took cognizance of industrial diseases: Hippocrates described lead colic as well as the toxic properties of this metal. Galen cited diseases peculiar to miners, tanners, fullers, chemists, and others. In the *Sallier Papyri* one may read of the effects of certain occupations upon the Egyptians of an early day. Even a form of industrial hygiene was practiced by the ancients, for Pliny the Elder writes that in certain dusty trades the workmen tied bladders over their mouths to prevent the inhalation of dust. Many of the earlier physicians, such as Agricola, Martial, Celsus, Dioscorides Pedanius, and Herodicus, have discussed the influence of occupation upon the health of workers. But intriguing and romantic though its history may be, this paper is too limited to permit a discussion of all of the important personages in the field of occupational medicine who have preceded our own generation.

RAMAZZINI

One name, however, cannot be passed over lightly, for it is more brilliant than all the others. In the seventeenth century there was born in Capri, in 1633, the patron saint of industrial medicine, Bernardino Ramazzini. His ability to observe, investigate, and then to de-

scribe with a facile pen has been matched but rarely since his death in the year 1714.

Many honors came to Ramazzini. Because of his learned dissertation on "febris tertiana" he was elected a member of the Academie de Caesareo-Leopoldina at Vienna. He was invited to lecture at the University of Padua, where he made several noteworthy addresses. During his twenty-nine years at Modena he wrote a great number of treatises and books on a wide variety of subjects, but only one of these will be mentioned at this time; namely "De Morbis Artificum Diatriba (The Diseases of Workmen)."

Ramazzini spent many hours among the more sympathetic craftsmen of his community. It was then that he became interested in the occupation of well diggers. Not content with talking to these workers in their "off-work" hours, he would himself descend into the wells, equipped with thermometer and barometer, to talk with the diggers, inquiring as to their health and what effect underground work had on them; he made observations on subterranean waters and on the characteristics of the antiquity in the different layers of the earth, their odors and gases. He also acquainted himself with the trades of silk workers, painters, dyers, glass makers, tanners, bakers, stone workers, metal workers, chemists, and others. All told, his famous book contains forty chapters dealing with the various diseases of working men.

In addition to his vivid descriptions of the occupational diseases of his day, Ramazzini left two statements which bear repeating, not as simple observations but rather as dictums worthy of adherence by all who would practice this form of medicine. The first of these was his exhortation to all physicians to ask of their patients not only the usual questions regarding their health but also to inquire without fail "Of what trade are you?" The other command of the old master was that physicians should learn the nature of the occupational diseases in shops, mills, mines, or wherever men toil. Osler believed that clinical medicine is best learned at the bedside of the sick in the hospital, but Ramazzini taught that occupational diseases are most effectively studied in the actual environment of the workers.

It is said that most famous men are not appreciated until some years after their death. With Ramazzini, the reverse is true, for he became famous and was admired in his own life time, only to be almost forgotten during the succeeding decades. Recently, however, his memory, his deeds, and his books have been revived by the founding of the Ramazzini Society in America, a group of 31 devotees of industrial medicine. It is the unwritten purpose of this

group to stimulate the practice of industrial medicine in the United States.

In the eighteenth century Percival Potts became interested in the cancer of chimney sweeps, while Willan described the skin lesions of bakers. The efforts of Thomas Percival, a Manchester physician, led to the first Factory Act in England. In Germany, Tissot was concerned with the hazards of stone masons, while phosphorous, the dusts, and toxic gases were also mentioned in the German literature. Following the industrial revolution, the English Factory Act of 1833 stimulated similar movements in Germany and France. It was then that the "De Morbis Artificum Diatriba" was republished and widely distributed, urging the people to enact better legislation.

20th CENTURY

In the twentieth century in England, Sir Thomas Oliver published "Dangerous Trades," followed by "Diseases of Occupation" (1908). In collaboration with Sir Kenneth Goadby, Sir Thomas Legge wrote "Lead Poisoning and Lead Absorption." About the same time, phosphorus poisoning received the attention of Andrews in the United States. Also in this country, Gillman, Thompson, Kober, and Hayhurst, to mention only a few of the pioneers, added important contributions to the literature dealing with industrial diseases. Admitting the omission of many other important names in the field of industrial diseases, we may expect that time and history will pay full tribute to those who, by their investigations and the promotion of industrial hygiene, have made the United States the most progressive country in the world for the protection of the working man. However, it would be an inexcusable omission indeed not to honor the most famous daughter of Ramazzini, Dr. Alice Hamilton, who, in the early years of this century, climbed the dilapidated steps of Chicago slums to visit men stricken with lead poisoning. She travelled the breadth of this land to investigate different types of occupational exposure; she wrote many articles and is the author of several books, one of which "Industrial Prisons in the United States" was a monumental contribution when it first appeared and still remains a very valuable work. By her works she deserves a place among the great physicians who have influenced the course of American medicine.

If industrial medicine is of such ancient origin, the question must be asked what has prevented it from achieving a status comparable to that of other branches of medicine. There are those who would answer that in the United States industrial medicine in its earlier years fell into evil ways; that it became "contract practice," "insurance medicine," or "finger wrapping." To a certain degree this is true. Too often industrial

medicine was only a stopgap for those whose interest lay in more lucrative fields. And yet, all these explanations are correct only in a superficial sense.

THE CHANGING ORDER

For the real answer one must look deeply into the social and economic history of the United States and begin by asking questions of a different nature, as, for instance: Why is it that America has no adequate system of rural medicine? Why has this nation lagged in its nutritional program, and in slum clearance? In the correct answer to these questions will be found the reason why industrial medicine has been late in reaching the prominent position which corresponds to its great importance. Only within our own time has this country begun to recognize its social problems and responsibilities. Except for the occasional lone voice, our social and economic philosophy has ignored mass welfare. Industrial management, generally having had little sound medical advice, was no more interested in the working environment of its employees than it was in their living conditions outside the plant. How then was it possible for industrial medicine to grow?

Organized medicine is likewise to blame. Far too long it has frowned upon the practice of industrial medicine, or at least has lent it no encouragement. Those who controlled the policies of our medical societies believed that industrial medicine threatened to undermine the cherished patient-physician relationship. Yet, to no appreciable degree has that relationship ever been disturbed by industrial medicine. What the leaders of organized medicine did not realize until recently was the necessity of a program to provide medical care for the people who cannot afford the manifestly excessive costs of adequate medical care. They did not consider that tuberculosis, venereal disease, malnutrition, cancer, and the like are group problems which can best be prevented by utilizing the machinery which controls and motivates large groups. Until lately it has not been understood that an industrial organization is a social structure which lends itself to a considerable degree to the cultivation of good human relations and to the promotion of good health in the community. This was demonstrated by the high degree of efficiency attained by the industrial tuberculosis program of World War II, through which a greater number of early cases of tuberculosis were detected than through any community-sponsored program.

Likewise, medical education has placed little emphasis on industrial medicine. Under these circumstances it cannot be expected that students will be seized with a zeal to enter the field of industrial health; and even if they did

so, they could scarcely be equipped for such a task so long as industrial medicine is taught in a half-hearted manner by inexperienced teachers to whom the teaching of this subject is delegated while they are engaged in lecturing on subjects largely unrelated to industrial medicine.

So much for the past and its obstacles. What of the future? Its possibilities are limitless and unpredictable.

ATTITUDE OF INDUSTRY

For the past few years nearly every union contract written, of which there are thousands written annually, contains some sort of health clause requiring the provision by management of health service in some form. This demand has occurred so suddenly and on such a scale that the medical profession is caught flat-footed, wholly unable to meet the demand. America has seen a need for a type of medicine which the profession itself failed in large measure to anticipate.

Medicine in industry is no longer limited to medicine per se. It is a varied and extensive service requiring an industrial physician who has had undergraduate and postgraduate training in this type of medicine and has served an in-plant internship and/or a year or two of apprenticeship in industry. He needs a fundamental knowledge of industrial hygiene, toxicology and human relations in addition to excellent training in medicine and some background in surgery and psychiatry. He is a specialist whose training must encompass a much broader scope than that required of the internist or the surgeon.

Obviously, until medical education can rearrange itself to provide such specialists, physicians self-educated in matters of industrial health must attempt to satisfy the present need.

Concomitantly, engineers inadequately trained in the techniques of environmental survey and control must educate themselves to meet the present demand until, by a combined effort, the engineering and medical colleges can supply adequately trained industrial hygiene engineers.

Schools of pupil health are likewise deficient in preparing our local, state, and Federal public health officers to administer the laws providing for the maintenance of health among working people.

While these three groups of educators are admittedly at fault in their failure to anticipate and meet the present enormous need for skilled specialists in this field, none of them is indifferent to it.

NEW EDUCATIONAL PROGRAM

At least nine medical colleges are now actively engaged in plans to develop graduate education in industrial medicine and many others are enlarging their undergraduate programs. The

Schools of Public Health are broadening their programs and several of the engineering colleges are studying the methods by which they may hold up their end of the load.

In the medical field, which is our concern today, at least four commendable trends are apparent.

(1) To help the physician educate himself to meet the immediate situation, several medical colleges are providing postgraduate courses for a few weeks each year. The leading men in the field are giving unstintingly of their time and knowledge to help to make these courses thoroughly worthwhile.

(2) The Council on Industrial Health of the American Medical Association is prodding medical educators to improve undergraduate teaching in industrial medicine. The big difficulty here lies in the fact that medical curricula are already overburdened. I believe that the secret of success will lie not alone in increasing the hours spent on industrial medicine per se but rather in infiltrating all courses from anatomy on up through the clinical years with more and more examples and illustrative material from industrial medical practice. This same group, working jointly with the Council on Medical Education, is trying to develop some sort of a residency system in this field comparable to residencies in medicine and surgery. Here, I think, in the past they have missed the point. The place to learn medicine is at the bedside. The place to learn surgery is in the operating room. The place to learn industrial medicine is in the factory! The A.M.A. is having to reorient its thinking to the end that it will recognize selected industrial medical departments for special training, just as it recognizes selected hospitals today.

(3) A few large and farsighted industries are attempting to develop adequate in-plant training programs for their industrial doctors.

(4) At least two formalized postgraduate educational programs leading to advanced degrees in this field are now in operation and others are to follow within a year or two.

The Institute of Industrial Health here in Cincinnati provides a three-year training program for a few carefully selected men on fellowships provided by industry. Two years are spent in clinical and didactic work covering industrial physiology and toxicology, industrial medical practice, preventive medicine in industry, human relations investigation, and the legal and engineering aspects of industrial medicine which industrial physicians need to know. The third year is spent in industry and completion of this training, for which two years' hospital training is a prerequisite, will lead to the degree of Doctor of Industrial Medicine.

A less extensive, but equally practical pro-

gram, is also in progress at the University of Pittsburgh and a similar one will be available at New York University within a year. These are but the infant struggles of what will soon become a large vigorous, robust and curious child. His manhood is still beyond my vision but I feel sure that he will take his proper place with dignity and distinction.

NEW PERSPECTIVE NEEDED

Whatever the shape of things to come may be, it is quite apparent that all of us have to develop a new perspective. Industrial medical practice is not the business of wrapping up cut fingers and opening boils. In fact in the not too distant future, we may measure the extent to which the industrial physician fails successfully to perform his tasks by the number of occupational diseases and accidents which he is called upon to treat. The task of industrial medicine is to foster health and prevent disease. Furthermore, we must begin to see that the economic aspects of the coveted "doctor-patient relationship" can and often must be wholly independent of that relationship. No matter by whom the physician is paid he is obligated to maintain his professional integrity and to give only sound advice based upon an honest and sincere regard for the health of the persons for whom he is responsible. Certainly, unless he is willing, he need not be the hired servant of management nor the partisan of the labor organization. Indeed the better his training, competence, and judgment, the more independent he will be in his professional capacity. His professional conduct must be unassailable by the individual patient, by organized labor or by management. To establish and maintain such a position he must have an intimate knowledge of the industry in which the personnel for whose health he is responsible are employed; this in addition to an intimate knowledge of the people and the disease which he attempts to prevent or is forced to treat. Obviously such a task cannot be accomplished by any part-time practitioner whose primary concern is private practice. Most practitioners cannot even hope to treat occupational disease intelligently because correct diagnosis and successful treatment frequently depend upon an intimate knowledge of the working environment from whence the patient comes.

Industrial medicine as a legitimate specialty in its own right will be recognized, I sincerely hope, on the merits of its practitioners. Let us prepare ourselves to help it develop rather than put obstacles in its path. Let us learn to recognize its competent practitioners by their abilities and by the fruits of their labors and not complicate the picture of the medical profession by the institution of more and more artificial means of recognition.

The Treatment of Selected Cases of Bone Sarcoma by Resection and Bone Transplantation

DALLAS B. PHEMISTER, M. D.

THE established treatment of sarcoma of bone located in an extremity with freedom from signs of metastasis is amputation. Irradiation therapy alone has rarely resulted in a permanent cure and frequently produces little palliation.

The prognosis following amputation for bone sarcomas as a group is poor. There was approximately a 15 per cent five-year survival rate with freedom from recurrence among the cases of the Registry of Bone Sarcoma of the American College of Surgeons up to 1939, but a considerable percentage of cases passing the five-year mark have remained well. Considering the high mortality from recurrence, the great physical, mental, and other handicaps resulting from amputation, and the reluctance of many patients to submit to the operation, serious consideration should be given to treatment of selected cases by resection and transplantation. Resection of sarcoma of certain bones of the rest of the body, as the mandible, clavicle, ribs and ilium, has given results not greatly inferior to those obtained by amputation for sarcoma of extremity bones. I have treated four such tumors that have not recurred after long intervals; a reticulum cell sarcoma of the clavicle after 22 years, a fibrosarcoma of the ilium after 12 years, a fibrosarcoma of the mandible after 8 years, and an undifferentiated round cell sarcoma of the scapula after 6½ years. In case of sarcoma of a limb bone, there is greater danger of local recurrence after resection and transplantation than after amputation; however, in well-selected cases the risk is only slightly to moderately increased and often the patient or the parents, in case of children, elect to take the risk in an attempt to conserve the limb. If subsequently there is local recurrence, amputation may then be performed provided there are no metastases.

The first resection of a bone sarcoma and successful repair of the defect was reported by Eiselsberg in 1897. The second was by Bier in 1897, reported by Klapp in 1900. Lexer and Albee were the first to report groups of cases yielding some worth-while results.

There is little evidence that wide local resection, especially if performed during tourniquet constriction of the extremity, increases the incidence of metastases. Patients developing signs

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The Author

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of metastases after either resection or amputation nearly always had unrecognizable metastases before the operation.

Resection and transplantation should be considered if the lesion is of small size, short duration, slowly growing, and favorably located so that indispensable structures as the main limb vessels do not have to be sacrificed. Some sarcomas are more favorable for resection than others. Chondrosarcoma, giant cell sarcoma, and reticulum cell sarcoma comprise the most favorable group as they usually grow slowly and metastasize relatively late. Osteogenic sarcoma, which comprises about one-half of all bone sarcomas, is the least favorable for resection because of the high incidence of early metastasis and the marked tendency to local recurrence. The results in a small group of fibrosarcomas have been unfavorable because of the subsequent appearance of metastases. Angiosarcoma is also unfavorable because of the early development of metastases.

Recent advances in knowledge of the fundamental principles of surgery have made it possible to perform more extensive resections and transplantations than was formerly the case. Adequate blood transfusion has greatly reduced the incidence of shock, as has also the efficient use of the tourniquet particularly when applied at the level of the hip above a Steinmann pin during resection of the femur. The use of massive bone grafts possessing 75 to 100 per cent of the strength of the missing segment of bone favors rapid repair of the defect. However, they predispose markedly to infection and loss of the grafts which formerly was a great drawback to extensive excision and transplantation for sarcomas of the femur, humerus and tibia. The recent use of penicillin and sulfonamides has definitely reduced the incidence of infection and enhanced the success of transplantation. Prolonged cast and splint support of a weight-bear-

ing extremity during the period of creeping replacement of the dead bone of the graft by new bone is indicated to prevent the occurrence of pathological fracture.

Once the decision has been made to treat the sarcoma by resection and transplantation, it is best to dispense with irradiation therapy which tends to increase the frequency of wound infection and interfere with the success of the bone graft.

A defect of an entire segment of femur or tibia is best treated by two grafts cut from one or both tibiae according to the case. Each graft comprises 30 to 40 per cent of the circumference of the shaft including the tibial crest. Anchorage should be made by either intramedullary insertion of the end or the use of metal screws or more frequently a combination of the two according to the case. Defects of the upper end of the humerus are best repaired by two grafts taken from a tibia. One graft should be 3 or 4 cms. longer than the defect with the lower end reduced and fitted snugly into the medullary cavity. The other should be the length of the defect and tied snugly to the first graft. A defect of the radius or ulna should be treated by a single tibial graft anchored to the fragment usually by two metal screws.

OPERATIVE EXPERIENCE

Altogether I have operated on 23 cases of bone sarcoma by resection and transplantation. In two other cases bone transplants comprising a healthy segment of the amputated tibia have been inserted into the stump at time of amputation of the thigh for the better support of an artificial limb. The selection of cases for resection and transplantation has sometimes been fortunate in that the tumors operated on were small and relatively benign, but in other cases it has been ill advised in that the disease was more malignant or had reached more advanced stages than was compatible with success. The decision to operate in the latter group has often been influenced by the wish of the patient who either flatly refused amputation or elected to take greater chances of recurrence in order to conserve the extremity. On the whole, the group is probably somewhat more favorable for the type of treatment employed than has been the average case of sarcoma treated by amputation, often in much later stages. Of the 23 cases treated by excision and transplantation, 14 died of recurrence of the sarcoma, and one of an accident six months after operation without signs of recurrence. One patient with a chondrosarcoma of the upper metaphysis of the tibia, free from recurrence after four years, was lost sight of. One patient who has survived for 14 years following operation for a post-irradiation giant cell sarcoma of the lower ulna

was free from recurrence until 16 months ago when tumor again appeared bordering on the operation site. It was excised, and at present there is no sign of recurrence. One patient is alive and free from local recurrence two and a half years after resection of a fibrosarcoma of the lower end of the femur but there are now signs of pulmonary metastases. The remaining six patients have been free from both local recurrence and metastases from periods varying from seven years and three months to eleven years and ten months, and are briefly reviewed here.

CASE REPORTS

Case 1, osteogenic sarcoma of humerus. A 28-year old male, dentist, gave a history of an increasingly painful swelling in the upper end of the right humerus for four months. Examination revealed an oval swelling of the upper three inches of the right humerus most marked laterally. A roentgenogram revealed uniform marked increase in density of the epiphysis and approximately three inches of the upper shaft of the humerus, and an oval shadow on the lateral surface with rays of bony density extending into it from the shaft. The lung fields were negative. A diagnosis was made of osteogenic sarcoma. At operation, the involved portion of shaft, the entire deltoid muscle, the muscular attachments to the tuberosities, and the joint capsule were excised, and a heavy tibial bone graft was inserted with small onlay grafts for arthrodesis of the shoulder. Pathological examination revealed a markedly ossified osteogenic sarcoma of rather high grade malignancy involving the entire interior of the resected segment except the lower 2 cms., and forming a slightly ossified small subperiosteal layer laterally in its upper half. The large graft united to the scapula proximally and to the humerus distally, but four months later it fractured in its upper third. Subsequent bone transplantations were performed but the pseudarthrosis persists and functions in part in place of the shoulder joint. Good function of the arm has been recovered and the patient has done full dental work with the arm for the past 10½ years.

This is the best case of the entire group since it represents a long term survival without recurrence of a rather advanced osteogenic sarcoma, a lesion which recurs and terminates fatally in a high percentage of cases after amputation. Six other cases of osteogenic sarcoma treated by resection and transplantation died with metastases, and three of them had local recurrences.

* * *

Case 2, chondrosarcoma of tibia. A 12-year old girl first noticed a painless swelling of the upper end of the left tibia about six months before examination in our clinic nine years and nine months ago. The lesion was then partly excised elsewhere and microscopically proved to be a cartilaginous tumor which was regarded as probably benign. There was further growth of the tumor which at the time of admission formed an oval swelling of the posterior side of the upper fourth of the tibial shaft. Roentgenograms revealed irregular bone destruction and blotchy shadows of increased density suggesting a chondrosarcoma. The upper 4½ inches of the tibia and the overlying skin and soft parts anteriorly were excised, going wide of the tumor. The defect was repaired by a heavy bone graft

inserted into the mesial femoral condyle and onlaid against the side of the fragment of tibia below, the upper end of the fibula being brought in contact with the lateral condyle of the femur. Examination of the specimen revealed a cartilaginous tumor producing an oval mass on the posterior and lateral sides of the upper three inches of the shaft with extensive infiltration of the cancellous interior. The microscopic picture was that of a chondrosarcoma. During plaster immobilization for three months there was bony union to both tibia and femur, and the graft gradually hypertrophied so that walking, at first in a brace, was resumed in seven months. There has been no recurrence of the tumor and she now has a useful weight-bearing extremity with ankylosis of the knee and about one and a half inches of shortening.

* * *

Case 3, chondrosarcoma of tibia. A 21-year old woman entered the clinic with a complaint of a slowly growing, slightly tender swelling of the anterior surface of the upper end of the tibia, first noticed about 3 years previously. An operation was then performed and a cartilaginous tumor removed. The lesion recurred and grew slowly, and a second operation was performed a month ago. On microscopic examination of the tumor, a diagnosis of chondrosarcoma was made. There were no complaints or abnormal physical findings aside from the region of the upper end of the right leg. There was a recently healed scar over the front of the upper end of the tibia but no palpable bony enlargement. There was a small, oval, soft swelling along the mesial side in the region of the lower end of the semi-membranosus tendon. A roentgenogram revealed an oval area of reduced density in the central portion of the end of the shaft measuring approximately 3 x 4 cms. and similar small lesion approximately 2 cms. beneath the larger one. A review of microscopic sections of the tumor removed a month previously led to concurrence in the diagnosis of chondrosarcoma. Amputation of the thigh was advised but the patient elected to accept operation by wide local excision of the involved parts and repair of the bone defect by transplantation. An elliptical incision was made from the mesial side of the patella going wide of the old scar, and the skin and subcutaneous flaps were reflected mesially and laterally. The tibio-patellar tendon was divided near its insertion. An oval cartilaginous mass about 1 inch in length was found in the substance of the lowermost portion of the semi-membranosus tendon. The tendon was divided 1 inch above the swelling. The muscles were reflected from the lateral side of the upper 4 inches of the tibial shaft. With a motor saw, cortex was severed anteriorly, mesially and laterally and a block of bone was excised which comprised all of the upper 4 inches of the diaphysis except the posterior cortex. The defect was repaired with bone removed from the shaft of the tibia below, the detached tibio-patellar tendon being anchored to one of the grafts firmly fixed in the defect. Examination of the specimen revealed small areas of a low grade myxo-chondrosarcoma in the periphery of the tibial defect that had been curetted and a similar island 2/3 cm. in diameter located 2 cms. below. The mass in the terminal portion of the semitendonsus tendon consisted of a richly cellular lobulated myxomatous tumor with islands of cartilaginous tumor about the periphery. There was a mild infection and loss of a part of the grafted bone. The wound then

healed and there was complete restoration of function in the limb, including motion in the knee joint. The patient is now free from evidence of recurrence of the tumor 7 1/4 years after operation.

Histologically the tumor is a borderline lesion but the extension to the semi-membranosus tendon being in the nature of a metastasis places it definitely in the group of low grade chondrosarcomas.

* * *

Case 4, chondrosarcoma of femur. An 11-year old girl entered the clinic 8 years ago because of pain and swelling at the junction of the lower and middle third of the right femur of four months duration. Sixteen months previously the region had been operated on elsewhere because of similar complaints and a richly cellular cartilaginous tumor removed from the interior. A roentgenogram revealed a long, dense, spindle-shaped thickening of the shaft with a central oval region of reduced density approximately 2 1/2 inches long. Under the diagnosis of slowly growing central chondrosarcoma and with a constrictor applied over a Steinmann pin at the level of the hip, a segment of the femur 15 cms. long was excised and the defect repaired by two heavy bone grafts taken from the tibiae and anchored to the fragments by threaded wires. Longitudinal section of the specimen revealed a soft bluish-grey centrally located oblong mass surrounded by a thickened cortex, and sclerotic bone filling the medullary cavity above and below. Microscopically the central lesion was a richly cellular hyaline cartilage tumor of low grade malignancy. During the four months period of plaster immobilization, union was established between grafts and fragments, and walking in a splint was begun during the 8th month. The graft soon hypertrophied and rounded off into a tubular bone, and motion in the knee was gradually restored almost to normal. The patient has walked normally on the limb without support during the past seven years and there has been no sign of recurrence of the tumor.

The case is an excellent illustration of rapid and successful repair of a defect of the femur by massive bone transplantation and of complete recovery of function of the extremity.

This experience with four cases of chondrosarcoma of low grade malignancy including the one lost sight of after four years indicates that such lesions are particularly favorable for treatment by local excision and transplantation. Two of the cases dying of recurrence after resection had chondrosarcoma.

* * *

Case 5, giant cell sarcoma of lower end of femur. A 26-year old male had gradually increasing pain in the lower end of the left femur for six months, and swelling on the mesial side for two months before admission. There were no other complaints or abnormal physical findings aside from the region of the left knee. There was a soft oval swelling in the antero-mesial region of the internal condyle and limitation of motion in the knee to about 50 per cent of normal. Roentgenogram revealed circumscribed reduction in density of the entire mesial condyle and a small amount of the overlying shaft, and of the mesial portion of the lateral condyle, with a triangular shadow of new bone formation on the mesial side of the cortex above the region of reduced density. The periphery of the lesion was biopsied and a diagnosis of a giant cell sarcoma was made. With a constrictor applied

at the hip joint above a Steinmann pin passed through the muscles laterally, the large elliptical area of skin antero-mesially, the underlying quadriceps muscle, the lower 4 inches of femur, the entire knee joint and 1 cm. of the upper end of the tibia were excised and the defect repaired by two heavy grafts taken from the entire length of the cortex of the tibial shaft below. They were anchored to the femur above and the tibia below by threaded wires. Pathological examination showed the tumor to be a giant cell sarcoma arising in a benign giant cell tumor, a rim of which was still present along the lateral side of the neoplasm. Bony union occurred rapidly and in three months the limb was placed in a walking caliper splint. The grafts were gradually made over into a tubular bone and function restored to the limb except for ankylosis at the knee. There has been no recurrence of tumor during the seven and a half years that have elapsed since operation.

* * *

Case 6, reticulum cell sarcoma of the femur. A 13-year old boy entered the clinic eight years ago with a complaint that five months previously he developed pain and a swelling on the lateral surface of the upper part of the shaft of the left femur. After progressing for two months, a diagnosis based mainly on roentgenograms was made of sarcoma, and between 6000 and 7000 roentgen units were given. Since then the swelling had almost entirely disappeared, but roentgenograms revealed a peripheral oval crater with a shadow of surrounding new bone suggesting a sarcoma that was still active. With a constrictor applied at the hip above a Steinmann pin, 17 cms. of the shaft of the femur beginning 2 cms. below the lesser trochanter was resected along with the overlying vastus lateralis and intermedius of the quadriceps muscle. An examination of the specimen showed the tumor markedly shrunken. Microscopically the tissue in the crater contained a moderate amount of viable round cell tumor which has been diagnosed as reticulum cell sarcoma. Six weeks later the defect in the femur was repaired by two broad grafts taken from the tibiae which, combined, made a transplant about 80 per cent of the size of the missing segment of femur. The field became infected, the grafts loosened from the fragment above, and the dead cortex gradually separated from a layer of new bone formed from the periosteum, necessitating sequestrectomy at the end of five months. A partial defect of the shaft remained after the completion of healing at the end of eight months. Since then, bone has been grafted for repair of the defect on four occasions with a flare-up of the infection each time except the last but with eventual restoration of the missing fragment one year and seven months ago. The newly constituted shaft was considerably weaker than normal and between three and four inches shorter than that of the opposite side. He walked without support until six months ago at which time the femur was re-fractured in an accident, and non-union still persisted after five months of plaster immobilization. A month ago a double onlay bone graft from the ilium was applied across the line of non-union and the wound has healed without infection.

This has been our most trying experience with infection as a complication of massive bone transplantation after excision of a sarcoma previously treated by X-radiation. However, on the bright side, the patient although with an

extensively crippled limb is still free from signs of recurrence of the tumor, and the prospects of getting bony union and eventually a serviceable extremity are now good.

DISCUSSION

The incidence of long term survival of seven of these 23 selected cases, six of which have remained free from recurrence, is greater than that of the average run of sarcoma patients treated by amputation. This may be accounted for in part by the fact that amputation for sarcoma is frequently done late or as a palliative measure regardless of whether or not metastases are present. Another reason is that the 4 chondrosarcomas, 2 giant cell sarcomas, and 1 reticulum cell sarcoma fall in the classes of sarcoma which frequently are slowly growing borderline lesions that do not metastasize until late in the course of the disease. The material, while relatively small in amount, provides evidence that selected cases of bone sarcoma may be treated by radical local resection and bone transplantation with conservation of a useful extremity and survival results that are only moderately inferior to those following amputation.

Notes on Tuberculosis

To advocate the indiscriminate use of streptomycin, especially in moderately advanced or advanced cases of pulmonary tuberculosis, not only is premature but also carries with it certain dangers and drawbacks. Among the principal dangers in the use of this drug is its toxicity, which may seriously affect hearing, sight and kidney function and cause skin eruptions. At present, it can only be said that we have seen little in the treatment of well established pulmonary tuberculosis by streptomycin that gives cause for any great optimism regarding its curative value. *Com. on Tuberc., N.H. Med. Soc., New England J. Med., Oct. 23, 1947.*

* * *

Seventy per cent of all new cases discovered by mass X-ray survey are minimal and do not constitute a grievous public health problem. Most of those cases will be noninfectious; the disease process will be incipient; and the probability of serious progression, with adequate follow-up, will be slight. Such cases can be cared for by private physicians and public clinics, assisted by public health nurses and medical social workers. Sanatorium beds now occupied by noninfectious cases can be given over to far-advanced virulent disease which constitutes a menace to the local population. *Francis J. Weber, M.D., Ohio Pub. Health, Feb., 1948.*

Early Recognition and Treatment of the More Common Neurologic Diseases

I. MARK SCHEINKER, M. D.

THERE are certain neurologic diseases in which success of treatment depends largely upon its early application. The purpose of this presentation is to point out some of the early symptoms and signs whereby recognition of these diseases is facilitated.

Early recognition of neurosyphilis, brain tumor, cerebral abscess, subdural hematoma, and multiple sclerosis, for example, is indispensable to any measure of success in treatment.

NEUROSYPHILIS

It cannot be sufficiently emphasized that the diagnosis, so frequently made, of "C. N. S. syphilis" is inadequate. It is evident, for instance, that general paralysis requires treatment differing from that applied to cases of meningovascular syphilis. Hence, the practical importance of a proper clinical differentiation between these conditions.

The following classification, based upon clinical and pathologic grounds, is a simplified presentation of those forms of neurosyphilis which are most frequently observed:¹

1. General Paralysis
2. Meningovascular Syphilis
3. Acute Syphilitic Meningitis
4. Tabes Dorsalis

Allowing for the omission of extremely rare forms, the list is adequate for practical purposes.

GENERAL PARALYSIS

General paralysis is characterized by insidious onset with a large variety of "neurasthenic" complaints, such as increased fatigability, headaches, insomnia and anorexia. At this early stage its differentiation from psychoneurotic complaints may be extremely difficult. The following symptoms and signs are characteristic for the early stage of general paralysis:

1. Increased forgetfulness, especially for names and numbers. During examination this may be easily demonstrated by requesting the patient to remember a certain word and number, which he is asked to repeat after an interval of five or ten minutes.

2. Slight and almost imperceptible difficulties in speech characterized by a slight degree of

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slurring of words or omission of syllables. During the examination the speech disturbances may be demonstrated by requesting the patient to repeat words composed of several syllables. The same symptom might be demonstrated by asking the patient to write a complicated word. Omissions of syllables will show up in writing, as well as orally.

Quite often, in addition to slurring of speech, there is a characteristic quivering of the small muscles of the upper and lower lip which may be considered as an early symptom of general paralysis.

Difficulty in mathematical calculation, which is frequently noted, can be demonstrated by asking the patient to add or subtract small numbers.

And, finally, characteristic is a certain degree of unjustifiable optimism with regard to every day problems, associated with the tendency to overestimate his own intellectual capabilities and financial possibilities. This early symptom might be interpreted as a precursor of the full blown feature of delusions of grandeur characteristic for the late stage of progressive paralysis.

This loss of insight and impairment of judgment lead imperceptibly to slowly progressing dementia—the main symptom of the disease.

THERAPY

What is the practical advantage of early recognition of general paralysis?

There is little doubt that malaria, fever therapy, or penicillin applied in the early stage of the disease may result in complete clinical recovery and may prevent further progression of the morbid process. The same therapeutic meas-

ures applied in the later stages of the disease are of little or no benefit.

This clinical observation can be best explained by the histopathology of the disease. It is generally known that the influence of malaria or fever treatment is limited to the inflammatory process of general paralysis. It does not affect the degenerative cellular changes. The early stage of general paralysis is characterized pathologically by an extreme degree of inflammation and a minimum of cellular degeneration. Malaria therapy administered in this stage arrests the inflammation and prevents the development of cellular changes. The clinical recovery may, therefore, be complete. In those cases, however, in which the inflammatory process has not been arrested and the nerve cell degeneration has been allowed to progress, resulting in considerable cellular destruction of the cerebral gray matter, the malaria therapy cannot reverse the process; and the intellectual defects will thus persist despite treatment.

It should be noted that the extent of recovery through malaria treatment may, in some cases, be predicted from the cell content of the spinal fluid. Marked pleocytosis would indicate a more favorable prognosis, inasmuch as there is an extreme degree of inflammation susceptible to malaria or fever treatment. A small number of cells in the spinal fluid indicates a minimum of inflammatory reaction and, correspondingly, the prevalence of degenerative changes. Under these conditions there is little hope for recovery following treatment.

The practical significance of early diagnosis of the disease, before it reaches the irreversible stage of dementia, is thus self-evident.

MENINGOVASCULAR SYPHILIS

Meningovascular syphilis does not present many diagnostic problems. Its clinical manifestations, regardless of the stage of the disease, are demonstrated by transient "strokes" which, as a rule, react favorably to specific antiluetic treatment and often show a tendency to spontaneous recovery. Malaria or fever treatment is less effective (than in general paralysis) and their use, therefore, should be limited to early cases and to those rare forms which show a considerable increase of cells of the spinal fluid.

Specific antiluetic therapy (mapharsen combined with bismuth) is the treatment of choice in cases of meningovascular syphilis. The results obtained in various forms of neurosyphilis with penicillin are reported in detail in the monograph of Moore (1947).²

ACUTE SYPHILITIC MENINGITIS

Acute syphilitic meningitis may be seen frequently during the secondary phase of syphilis, or long after the initial infection, as an early

stage of meningovascular syphilis. There are, according to Merritt and Moore,³ three clinical groups of acute syphilitic meningitis. Group 1 is characterized by acutely developing hydrocephalus with headache, nausea, vomiting, and symptoms of meningeal irritation. Usually included there among are stiffness of neck and choked discs.

Group 2, mainly vertex in localization, is characterized by convulsions and focal symptoms. Group 3, essentially basilar in localization, is characterized by involvement of several cranial nerves. Of these the third and the sixth nerves are the ones most frequently implicated. Various forms of ocular palsies, associated with external or internal strabismus, are frequently observed. Facial palsies, deafness, and nystagmus may occur, but less prominently. Differentiation from septic purulent meningitis is based upon the presence of polymorphonuclear leukocytes in the spinal fluid, the history of syphilis, and the positive Wassermann reaction.

Differentiation from tuberculous meningitis is based upon the tendency to spontaneous disappearance of certain clinical symptoms and the absence of general signs of severe illness.

The spinal fluid is under increased pressure. The cells, mostly lymphocytes, range in number from hundreds to thousands. The blood and cerebrospinal fluid Wassermann reactions are strongly positive. No pellicle formation is present.

Cases of acute syphilitic meningitis react, as a rule, very favorably to penicillin treatment or to specific antiluetic therapy (mapharsen combined with bismuth).

TABES DORSALIS

The early symptoms of tabes dorsalis are characterized by paresthesias, in the form of tingling or numbness, along the distribution of the ulnar nerves; sharp, shooting pains, often misinterpreted as rheumatism; and, finally, early signs of disturbed equilibrium characterized by a slightly staggering gait which at first manifests itself only at night. (This is the precursor of locomotor and static ataxia, typical features of the advanced stage of the disease.) The deep reflexes are usually hyperactive in the early stage. The loss of tendon jerks becomes apparent with the progression of the disease.

Needless to say, Argyll Robertson pupils, frequently combined with pupillary irregularity and inequality, may be present at any stage of the disease.

Loss of sensibility to tactile and painful stimuli, associated with delayed sensation; profound alterations of position sense and vibratory sensibility, locomotor and static ataxia, gastric and laryn-

geal crisis, perforating ulcers of the feet, Charcot joints, all are manifestations of the more advanced stage of the disease.

The treatment to be recommended in the early stage of tabes is that of penicillin combined with fever therapy. The prognosis in most cases is quite uncertain.

CEREBRAL NEOPLASM AND CEREBRAL ABSCESS

Early recognition of space-consuming cerebral lesions is of paramount significance because they constitute a grave threat to life itself. The prognosis of surgical intervention often depends upon early recognition of the nature of the cerebral disease. It is therefore the responsibility of the general practitioner, who first sees the patient, to recognize some of the general signs and symptoms of space-consuming lesions. It is then up to him to report promptly to the neurosurgeon.

Early recognition of increased intracranial pressure is of great practical significance inasmuch as fatalities from the disease, whether with or without neurosurgical intervention, probably are in geometrical proportion to delays in recognition.

The clinical symptoms and signs indicative of increased intracranial pressure caused by space-consuming lesions may be briefly summarized as follows: Persistent, severe headaches should be regarded with suspicion if they remain unresponsive to general medical treatment. Repeated vomiting of projectile type associated with headaches, dizziness, and vertigo would seem to be indicative of vagal and vestibular irritation due to increased intracranial pressure. Slowly increasing drowsiness, when associated with periods of slight confusion, is a symptom of considerable significance. Papilledema is, of course, the most reliable sign of increased intracranial pressure. With the routine use of the ophthalmoscope, the chances are that it may be detected during the initial stage of the disease.

The development of a paresis of the lateral rectus muscle, signs of bradycardia associated with a drop in respiratory rate, mental confusion and stupor,—these occur in the late stages of increased intracranial pressure and are indicative of grave danger.

It should be emphasized that a lumbar puncture to determine the height of the intracranial pressure may be dangerous under certain conditions. If the intracranial pressure is considerably increased, only a minimum amount of fluid should be removed in order to prevent herniation of the brain stem through the tentorial opening, a condition that may bring on a rapidly fatal issue.⁴

In conclusion, it is stressed that early recognition of signs of increased intracranial pressure

often depends upon the alertness of the general practitioner. It is his responsibility to detect the process at the earliest time, when conditions are most favorable for effective surgical intervention.

SUBDURAL HEMATOMA

There is no classical symptomatology which is definitely characteristic for a subdural hematoma. In typical cases the following history and sequence of events are assumed to be characteristic: Immediate loss of consciousness at the time of injury to the head, followed by a so-called "lucid" interval during which the patient recovers consciousness and usually complains of severe headache; nausea and vomiting are frequently observed. The "lucid" interval, lasting from a few hours to several days, is followed by steadily increasing drowsiness, stupor and coma. At the same time, the following localizing neurologic signs may be manifest: rapidly progressing hemiparesis, focal epileptic seizures of Jacksonian type, extensor plantar reflex, facial weakness and dilated fixed pupil on the side of the subdural hematoma.

Clinical recognition of subdural hemorrhage would be simple if the "typical" sequence of events were uniformly in accord with the "rules" of textbooks, but this is seldom so. Only alert awareness on the part of the general practitioner of the frequent association of brain injuries with subdural hematomas and recourses to bilateral trephine openings as a routine diagnostic procedure in all cases of suspected subdural hematoma can assure early recognition of the process; and, at this stage, the removal of the clot may be considered as a life-saving procedure. The frequency of fatal results, despite surgical intervention, is explained partly by the fact that too much time is permitted to elapse between injury and removal of the clot. Prompt evacuation of the subdural clot is of paramount importance in order to prevent unilateral cerebral swelling of the brain, resulting in transtentorial brain stem herniation with subsequent perivenous hemorrhages and destruction of the vital centers of the midbrain.⁴

Clinical symptoms and signs that are, according to the author's experience, to be considered as helpful in the establishment of a diagnosis of subdural hematoma are: (1) Head injury followed by increasing headache, drowsiness, blurred vision, and mental confusion; (2) fluctuations in the level of consciousness from day to day; (3) inequality of the pupils, with dilatation of the pupil on the side of the lesion.

Too much emphasis cannot be placed upon the urgency of early recognition of subdural hematoma, followed by speedy evacuation of the clot. Constant vigilance and suspicion of its presence in every case of severe head injury are imperative. In a great number of cases the

final diagnosis of subdural hematoma can be made only by means of exploratory trephine openings.

MULTIPLE SCLEROSIS

The essential criteria for diagnosis of multiple sclerosis cannot be too inflexible since this disease is characterized by extreme variation in its clinical manifestations.

The diagnosis depends upon findings obtained from the history of the patient as well as from the clinical examination. Multiple sclerosis, as a rule, begins between the ages of twenty and forty. The initial symptoms may be precipitated by upper respiratory infection, by accident or injury, by emotional tension, by overexertion or nervous fatigue and sometimes by pregnancy.

Of much greater diagnostic significance are such early symptoms of the disease as: (a) Ocular or visual disturbances in the forms of transient diplopia, fleeting blindness or defective appreciation of color. These complaints often date back ten or fifteen years prior to the "paralytic" stage of the disease. (b) A common, early complaint is that of a limb becoming "heavy" or weak, and that it frequently (especially after exertion) "gives way" for a relatively short time. This may be associated with transient paresthesias, such as "tingling," numbness or coldness of the distal parts of one or several limbs. (c) Less frequent are complaints of such incipient symptoms as shaking or trembling in one extremity, staggering gait, awkward use of fingers in fine movements, difficulties in articulation, and vertigo. Impairment of sphincter control and faulty emotional balance, with the tendency to laugh or weep upon slight or no provocation, are comparatively rare in the early period of the disease.

The course of the disease is variable. Some cases begin in stormy fashion and run a rapid course. This acute, fast-advancing course, resulting in death within a few weeks or months, is characteristic of the acute form of multiple sclerosis.⁵ The large majority of cases, however, go on for many years with numerous remissions and relapses, yet with ultimately steady progression.

There is no agreement in regard to the cause of multiple sclerosis, and hence no specific "cure" is generally accepted.

Recently advocated as methods of treatment are the use of anti-coagulant drugs, such as dicoumarin (dicoumarol), and the use of vasodilating drugs.

Therapeutic measures advocated by the author are divided into: (1) Measures founded upon the author's theory of the pathogenesis of the disease. They are aimed at elevation of blood pressure and stimulation of circulation for the purpose of counteracting the vasoparalytic phe-

nomena which result in stasis and thrombosis of some of the small cerebral veins and capillaries. (2) Therapeutic measures aimed at alleviation of the myasthenia-like fatigability and muscle weakness. (3) A series of therapeutic measures that may be summarized under the heading of "morale building" and "psychotherapy."⁶

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Hypertension Today

It would not be amiss to open this discussion by quoting from the writings of Snapper, well known observer on diseases of the Orient: "In general, the diet of the native inhabitants of the Orient consists mainly of carbohydrates, with the fat and protein intake remarkably low. In most of the standard diets of the Occident, the ratio of carbohydrates to proteins and fats, by weight, varies around 4:1:1, that is, about 55 per cent of the total caloric intake is derived from carbohydrates, 14 per cent from proteins and 30 per cent from fats. In the Orient, however, 80 per cent to 85 per cent, sometimes even 90 per cent, of all the calories, is derived from carbohydrates, 5 to 10 per cent from proteins, and about 7 to 8 per cent from fats. Even this small amount of protein is mainly of vegetable origin. Since no animal fats are used, the cholesterol intake is practically nil . . . Whereas, in the United States blood cholesterol values of 250 to 300 milligrams per hundred cubic centimeters are customary, in the Orient the values usually range around 150 milligrams per hundred cubic centimeters. These low cholesterol readings are certainly not a genetic characteristic since careful studies have shown that the blood cholesterol of Javanese persons serving as waiters on luxury ships reached levels comparable to the Occidental figures." Snapper found that diseases connected with cholesterol infiltration are uncommon amongst Orientals and feels that the low blood cholesterol levels may account for the fact that arteriosclerosis is relatively rare in the Orient. It was not unusual that not a single case of coronary thrombosis was seen in the electrocardiography department of the Department of Medicine of Peiping Union Medical College during an entire year.—Max Koenigsberg, M.D., Charleston, W. Va. *Medical Jr.*, Vol. 44, No. 10, Oct., 1948.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

THE more rapid decline of the tuberculosis death rate in younger age groups and the gradual aging of the population have resulted in an increasing proportion of tuberculosis deaths in the ages over 45. Tuberculosis among older people is often unsuspected because the disease has long been considered the particular foe of youth. Although tuberculosis remains the leading cause of death from disease in the ages 15 to 35 the tuberculosis death rate increases steadily with age from a minimum in childhood to a maximum of 75 years of age.

TUBERCULOSIS IN THE OLDER AGE GROUP

The present practice of making extensive studies of tuberculosis in the younger age group of our population, thus minimizing the importance of the disease in the aged, has proved to be unwise.

The statement has been made that in persons over the age of 50 years the occurrence of communicable pulmonary tuberculosis is more frequent than in any other period. In 3,000 routine postmortem examinations made at the Philadelphia General Hospital from 1936 to 1937, 11.2 per cent of the 1,000 patients 60 years of age and over had died of tuberculosis. This and other evidence leaves little doubt that tuberculosis among older individuals is not rare.

The same irregular periods of activation and quiescence which are characteristic of tuberculosis occur in the older age group, and when continued, calcareous areas, fibrosis, fibrocaceous or fibrocavernous pathology finally develop. The disease among the elderly is usually of a chronic nature, and the patient continues with his occupation. One of the deficiencies in the control of tuberculosis is the failure to discover the disease in elderly individuals who may be spreaders of tuberculosis for many years.

A study of case histories of older patients having pulmonary tuberculosis gives the impression that the disease is usually acquired before 40 years of age though the time of onset is often difficult to determine.

Herewith are four illustrative cases:

CASE REPORTS

Case 1.—A farmer at 28 years of age had a profuse hemorrhage, which was diagnosed as being of gastric origin. Six years later a daughter died of tuberculous meningitis. Fourteen years later, in an accident, he was badly exsanguinated. He recovered and continued his farm work for 22 years apparently in good health. At 70 years of age he complained of a

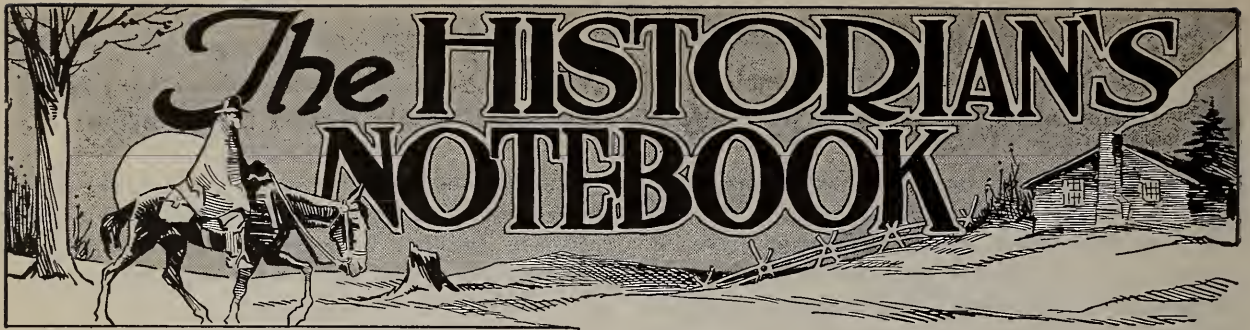
productive cough and had a low grade fever. A sputum examination made at this time showed tubercle bacilli. Two years later, he died of tuberculosis. This man apparently had pulmonary tuberculosis for 44 years.

Case 2.—A female, married for 22 years, had been in poor health, but as no clinical symptoms were present to suggest serious trouble her family physician concluded that she was a malingerer and lost interest. Another doctor later found abnormalities in her chest upon physical examination and tubercle bacilli were present in her sputum. This woman, now 68 years of age, is still living.

Case 3.—A seven-year-old female died of pulmonary tuberculosis 22 years ago. The family consisted of two brothers, a father, and mother. During a school tuberculin-testing program held later the two brothers showed positive reactions. The mother was thought to be the source of infection, but her sputum examinations proved to be negative. The father failed to cooperate, claiming that he was in good health. Later he made a poor recovery from influenza, during which he lost weight and acquired a productive cough. An X-ray of his chest then showed far-advanced tuberculosis. He died of tuberculosis at the age of 80 years.

Case 4.—Forty-six years ago a young man, then 16 years of age, had three quarts of fluid aspirated from his chest. Fifteen years later rales were found in his right lung apex. During the next few years physical signs were found in both upper lobes. In 1933 an X-ray of his chest showed marked involvement of both upper lobes and this had progressed to cavity formation by 1946. This man, now 69 years of age, appears in excellent physical condition and in good health.

It seems unreasonable to assume that repeated exogenous reinfections account for the course of the disease in such cases. Many of these patients date the beginning of their trouble back to only a few months, while their X-ray indicates a longstanding disease finally reaching a stage where a breakdown occurs. Physical examination does not materially aid in making a diagnosis. Spinal deformities, ossification of the costal cartilages, and a decreased vital capacity are encountered in older patients. These alter the signs on inspection and palpation. Upon auscultation the findings are often confused by the presence of other pathologic conditions, namely, bronchitis, bronchiectasis, asthma, heart disease, and, particularly, emphysema.



Some Important Contributions to Medicine Made By Clevelanders

HOWARD DITTRICK, M. D.

IN looking over the collections in the Howard Dittrick Museum of Historical Medicine, some objects were discovered which represent important contributions made to medical knowledge by residents of Cleveland. Cleveland has not been backward in honoring her outstanding sons for most of them who have made medical discoveries have been recognized officially and medals or citations have been awarded to them. There have been native sons who have made their mark in medicine in other places. In New York, Joseph O'Dwyer devised the intubation tube for treatment of diphtheria long before the use of antitoxin; in Baltimore, J. J. Abel, a teacher and investigator in pharmacology, was associated with Johns Hopkins; in Boston, Harvey Cushing won renown in brain surgery. Other Clevelanders made noted contributions during their residence elsewhere. J. J. Macleod won his share in the Nobel Prize for the discovery of insulin after he left Western Reserve University and became Professor of Physiology in the University of Toronto, while Elliott Cutler operated on the mitral valve in Boston before coming to Cleveland.

Some have toiled faithfully and efficiently, but the fruits of their labors have not been spectacular. In the Museum files there is a manuscript by Torald Sollmann written in his type of shorthand, a reminder of his textbook on pharmacology which has been published in seven editions. Many objects pertaining to early medicine in Philadelphia were presented to the Museum by Howard T. Karsner who has also been a successful author. Material relating to pioneer medicine in the Western Reserve came from Dudley P. Allen, who was a generous benefactor to Cleveland medicine. The head spanner of T.

This material was originally presented in the Festschrift published in honor of the medical historian, Professor Max Neuburger, on his eightieth birthday. It has been entirely rewritten for this publication.

Wingate Todd is indicative of his contribution to anthropology. At one time it was widely used but of recent years its use has been supplanted by roentgenologic studies. G. N. Stewart and J. M. Rogoff investigated the hormone in the cortex of the kidney. Their work formed the basis for subsequent isolation of that hormone. C. J. Wiggers also has achieved distinction for his researches in the physiology of the circulation. F. C. Waite, in addition to his teaching, has written several carefully documented books and numerous articles on the history of medicine, and has deposited in the Museum much of the material used in their preparation. Pupils now occupy similar positions to that of their professors in other schools from California to Oxford.

Health officers have faithfully served in that office to make Cleveland a safer place in which to live. Pasteurization of milk, filtration and chlorinization of drinking water were employed here early but probably our outstanding success in public health was the initiation of the Sane Fourth idea into a city ordinance. Very little material associated with health commissioners has been donated to the Museum.

The various advances referred to have been of local significance and occasionally of national importance. In subsequent pages of this article, discoveries of world-wide influence will be discussed, but will be limited to those associated with material to be found in the Museum.

I. CLINICAL APPLICATION OF BLOOD TRANSFUSION

In 1907, George Crile, Sr., made a noteworthy contribution to clinical surgery. He undertook to prove that transfusion was a desirable method of treating shock, hemorrhage and many diseases. At that time it was an accepted principle that "normal blood of individuals is physiologically interchangeable." In the light of subsequent events it would seem a courageous procedure to have employed transfusion so promiscuously,

yet he mentions only one fatality. The danger which concerned him most was the early clotting of blood and to overcome this he sutured the donor's artery to the recipient's vein. He developed spectacular teamwork in carrying out the operation, thereby increasing the number of favorable results.

In searching for new fields for use of blood transfusion, Crile used it for pernicious anemia, leukemia, carcinoma, chronic suppuration, tuberculosis, poisoning from carbon monoxide, shock and various types of hemorrhage. For septicemia and poisoning from drugs the patient was bled before the infusion was given. Crile even investigated the possibilities of blood transfusion in diseases where immune or protective bodies are found in the blood. For example, he transfused diphtheria and typhoid fever patients with blood obtained from patients who had survived these diseases.

In 1907, he reported positive results in acute hemorrhage. Improvement and control of the hemorrhage usually occurred in bleeding due to constitutional disease. In surgical shock and carbon monoxide poisoning better results were obtained than had been possible previously. In other conditions this new form of treatment did not prove to be satisfactory.

In those early cases, occasionally there were chills associated with the transfusion and a little later some elevation of temperature. No mention is made of any fatalities. However, two years later, he discussed² in greater detail, measures to be taken to prevent complications. Complete history and physical examination were required and careful observation of both the recipient and the donor was advised throughout the procedure. In the donor, the blood pressure, the size and elasticity of the radial artery, and the duration of the flow, and in the recipient the resistance of his vessels, all influenced the volume of the transfusion introduced. The amount withdrawn depended upon symptoms noted in the donor, such as pallor of the skin and mucous membranes, restlessness, rise in pulse and respiration rate, decrease in blood pressure, and tense facial expression. It was also necessary to watch the recipient for indications of cardiac dilatation and failure which might occur if the transfusion was too large in amount or too rapid in administration.

By this time, Landsteiner and others had reported that hemolysis might result from the mixture of blood of certain patients. To avoid such accident, Crile suggested that whenever possible preliminary tests for such a reaction should be made.

Furthermore, an improvement in technique was developed. Originally Crile sutured the recipient's artery to the donor's vein to prevent leakage. Through the cooperation of Dr. F. W.

Hitchings, who had been awarded prizes at Cleveland Museum of Art for his work in fashioning jewelry, a series of silver cannulas were devised from 1.5 to 3 mm. in diameter. The cannula was fitted with a handle to facilitate its use. The vein was drawn through the cannula and cuffed back. The artery of the donor was drawn over this cuff and sutured in place. After the transfusion was completed, the cannula was removed, both the artery and the vein were ligated and the wound closed. A set of these cannulas, including the first one made by Dr. Hitchings, were presented to the Museum by Dr. Crile.

Subsequently, transfusion was rendered safe by grouping patients according to appropriate blood types. The technique was simplified by treatment of the blood to minimize coagulation and also by use of apparatus such as the Kimp-ton-Brown tube.

Crile did not perform the first transfusion, but rather he called the attention of surgeons to its use as a therapeutic agent in many critical conditions. His simplification of the procedure and development of necessary teamwork, led to its universal adoption for treatment of acute hemorrhage and surgical shock. The wide use of blood transfusion in World War I and World War II is directly attributable to Dr. Crile's popularizing this method of surgical treatment.

Dr. Crile received many medals, awards and citations in Europe and the United States. He was recognized among his local associates for having directed the attention of the world to Cleveland Medicine.

II. THE PREVENTION OF GOITER

Four autographed reprints on this epochal work are preserved in the files of the Museum. Beginning in 1917, David Marine and O. P. Kimball published a paper annually until 1920 on the Prevention of Simple Goiter in Man.^{3,4,5,6} J. M. Rogoff was associated with them as co-author of the paper in 1919.

The authors began their work in the Outpatient Department of Lakeside Hospital in Cleveland with some clinical data obtained from the private practice of some of the staff members. The results seemed to justify more extensive investigation. The County Medical Society and School Board of Akron, Ohio, consented to institute prophylactic treatment among the pupils in their public schools from the fifth to the twelfth grades inclusive. Since goiter appears most often in adolescence and in six girls to every boy, the project was limited to school girls. The work of the first year consisted of a survey of all cases of enlarged thyroids among the girls. This formed a basis for comparison with subsequent data.

There had been considerable spade work done in animals before this school project was undertaken. It had been found that simple goiter in

animals was the most easily preventable disease. In man simple goiter occurs in endemic, epidemic, and sporadic distribution and includes all forms of enlargement of the gland except exophthalmic goiter. The time of onset occurs usually in utero, during adolescence, or during pregnancy.

Marine and Kimball based their plan of attack on the relation of iodine to the thyroid gland. The gland has a strong affinity for iodine, and, in the development of goiter, a decrease in the iodine content precedes any cellular changes, while compensatory hyperplasia also has some relation to the presence of iodine. Furthermore, it had even been found that goiter could be prevented in pups by giving them iodine. Although there was much pertinent data available regarding the influence of iodine on goiter in animals, there had been no extensive study to prevent or control the disease in man.

The method employed in the beginning of the investigation was the administration of 0.2 Gm. of sodium iodide once daily on ten consecutive days in May and December. This treatment was given to girls in the fifth, sixth, seventh, and eighth grades and double the dose to girls in the ninth, tenth, eleventh, and twelfth grades. During the first year's experiment, girls in all these grades were given the same dose of 0.2 Gm. The risk of bringing on exophthalmic goiter was found to be almost negligible. Those girls who refused to accept the treatment proved useful as controls.

Experience of the first year's treatment was very satisfactory. In girls with normal thyroids not one who took the treatment developed any enlargement of the gland, while in those who did not take treatment 26 per cent of thyroids were definitely enlarged. Among those treated one-third of the small goiters disappeared and one-third of the moderate goiters were decreased 2 cm. or more in size. The iodine had both a prophylactic and therapeutic effect. Less than 0.5 per cent of the girls developed any rash and when this did occur it was of minor concern.

Furthermore, although the treatment was optional, it proved to be popular, 1,080 pupils submitting to it in the first year, and 2,000 in the second. The investigation lasted over a period of thirty months during which observations were made on nearly 10,000 children. The prevention of goiter during adolescence was shown to be a public health measure which could be carried out very simply and economically. During pregnancy enlargement of the thyroid in the mother or her baby may be similarly prevented, but this responsibility rests in the hands of the private practitioner. As a result of general adoption of goiter prevention, surgical services in hospitals have shown a decided decrease in the number of thyroidectomies.

This investigation represented several years'

work even before the project was begun. Efforts are still being carried on to make the proved benefits available everywhere. The technique has been greatly simplified by the authors. Practically the same effect can be obtained by having the manufacturer introduce a small amount of iodide into common table salt. Such a method involves little or no effort and prevention is automatic. This research problem was applied to school children only after it had been successfully worked out on animals. The work of these authors should be followed up by insisting upon universal legislation authorizing incorporation of iodide in all table salt.

Marine later moved to New York where he was awarded a medal by the New York Academy of Medicine. Kimball remained in Cleveland and has continued active work in the prevention of goiter.

III. THE SLIDE PRECIPITATION TEST FOR SYPHILIS

For many years the Wassermann test has been considered the standard laboratory procedure in the diagnosis of syphilis. However, there has always been a recognized fraction of error which researchers have been striving to eliminate. Eagle, Hinton, Kahn, Mazzini and Kolmer were other workers in this field. The multiplicity of investigators and methods led to confusion and an endeavor was made by Cleveland serologists to evolve a test so simple and accurate that it would be universally adopted.

An exhibit in the Museum representing the slide precipitation test consists of the materials used in the procedure and a collection of reprints describing the various stages in its development. The test was first described by Benjamin S. Kline and Anna M. Young⁷ in 1926.

The Kline test was made on a glass slide 2" x 3" on which twelve paraffin rings were fixed. Within each ring 0.05 cc. of the patient's undiluted serum was introduced. By means of a pipette, 1 drop, 0.008 cc. of antigen emulsion was instilled into the serum. The slide was then rotated for four minutes on a flat surface. The number and size of clumps that occurred were observed under the microscope and then recorded. This step is similar to that utilized in interpreting the Vidal reaction.

The slide precipitation test proved to be more sensitive than the Wassermann test and even as specific. The test was not affected by humidity in the laboratory and consequently it was unnecessary to use a humidifier cover. It was advisable to maintain the room temperature at not less than 70 F., and to make certain that all materials and apparatus were warm.

The changes that were made in improving the test concerned chiefly the type of antigen employed. At first the antigen was the same as

that used by Kahn, but this was unsatisfactory and an ether insoluble alcoholic extract of beef heart powder was utilized. In 1941, Pangborn⁸ introduced a cardiolipin lecithin antigen. Kline worked out the most effective proportion of cardiolipin to lecithin and then adopted the Pangborn antigen for the slide precipitation test. With this method Kline⁹ reduced the false positive reactions from 0.3 per cent to 0.006 per cent.

In medicine it is always hazardous to claim that perfection has been attained. Discoveries in materials and technique open up new avenues for investigation. However, Kline believes that the results obtained from this test by using the Pangborn antigen have proved trustworthy and that the degrees of flocculation are easily determined. For these reasons the Kline test should be recommended for a simple universal standard test for syphilis. Dr. Kline has been awarded honors by local and national organizations. Syphilologists, clinical pathologists and public health officers have recognized the value of his contribution toward the simplification and standardization of the diagnosis and treatment of syphilis.

IV. THE CONDENSER DOSIMETER

The fourth Museum accession, the condenser dosimeter, was presented by Otto Glasser of Cleveland Clinic. This electrophysical unit for the measurement of radiation was first described by the authors¹⁰ at the Second International Congress on Radiology, held in Stockholm in 1928. A modification of this apparatus is employed today in all X-ray therapy departments to measure the dosage.

Previous measurement of dosage in radiation was unsatisfactory because of lack of suitable instruments. Accurate determination of gamma ray dosage in R-units and a mensurable comparison of the electrostatic R-unit with the Solomon R-unit were both impossible. These and other needs led to the construction of the dosimeter.

The dosimeter is made of two parts, a condenser with an ionization chamber attached, and a string electrometer with a static charger. The condenser unit is connected electrically with the electrometer unit and the entire system is charged to a known potential as indicated on the electrometer scale. The condenser unit with its ionization chamber is then placed in the field of radiation about to be measured. After a definite time the loss of charge is observed on the scale and the condensed unit is returned to the electrometer. By proper selection of the material and size of the ionization chamber, and with knowledge of the electric capacity and volt sensitivity, it is possible to convert the loss of charge observed on the scale into R-units. To ensure that the radiation shall affect only the ionization

chamber of the condenser unit the charger part of the system is entirely surrounded by non-conducting material. Radiation intensity is registered at any distance from the electrometer by the condenser unit which is itself fully protected from stray radiation and can therefore measure the R-units of penetrating gamma rays of radium.

By allowing the dosimeter unit to remain in position a longer time than usual it is possible to determine any harmful stray radiation. This same principle has been slightly modified to afford protection against overdosage of all forms of radiation, X-ray, radium and neutron.

The development of the dosimeter standardized the number and duration of roentgen exposures. It is now used in practically every institution in the world where the roentgen ray is employed. In 1936 the Radiological Society of North America awarded Dr. Glasser a gold medal in recognition of the importance of the dosimeter to radiology.

V. ARTERIAL HYPERTENSION AS A RESULT OF RENAL ISCHEMIA

The fifth famous Cleveland medical discovery is represented in the museum by a small ingenious silver clamp used by Dr. Harry Goldblatt partially to constrict the renal artery in studying the relation of the kidney to arterial hypertension. The results of this investigation were published in 1934.¹¹

Among the many workers engaged in the problem of hypertension, many had attempted to work out a solution by producing various forms of injury to the kidney. Elevation in pressure was obtained, but it was only temporary. Renal ischemia was suggested as a possible causative factor and Goldblatt undertook by animal experimentation to determine whether or not "ischemia limited to the kidneys may be the initial condition in the pathogenesis of the hypertension that is associated with nephrosclerosis."

Constriction of the renal arteries appeared to be the most direct method for making further observations, but this was fraught with many difficulties. After much discussion and many consultations, the little silver clamp was devised with two plates one of which could be removed for placing the artery in the clamp. Since the manipulation had to be carried out deep in the wound, special accessory instruments were also devised. The renal artery was first dissected free from its bed, one plate removed from the clamp and the artery placed within the clamp. The plate which had been removed was then replaced and with the special instrument the position of the clamp was reversed so that the screw could be tightened by a screw driver. The amount of constriction was accurately determined, the clamp

left in position on the artery and the wound closed.

"The results of the foregoing experiments show that the constriction of the main arteries of both kidneys in dogs was followed invariably by elevation of systolic blood pressure, determined in a carotid artery, which persisted for as long as fifteen months. These experiments indicate that, in dogs at least, ischemia localized to the kidneys is a sufficient condition for the production of persistently elevated blood pressure."

In spite of a vast amount of research, arterial hypertension still retains a prominent place in mortality tables. However, the work of Goldblatt has demonstrated the positive influence of renal ischemia. Several medals and other honors have been awarded to Dr. Goldblatt and recently, in California, a special laboratory after his own design has been constructed for him to continue this important type of investigation.

VI. THE WETZEL GRID

The final Museum display to be discussed is made up of a number of charts with an autographed article explaining the use of the Wetzel Grid. These graphs have been worked out through higher mathematics and plot the growth in height and weight under various conditions of health and environment. Norman C. Wetzel, on March 22, 1941, published the result of his investigation on growth under the title "Physical Fitness in Terms of Physique, Development and Basal Metabolism."¹²

The Grid is furnished in standard forms and is suitable for use in schools, clinics, health services and private practice. Observations of the weight, height and age are entered on the Grid, and the course of these entries indicates progress in physique, development, nutrition and age advancement. The Grid can thus aid in determining the physical condition and progress of the individual throughout the years of maturity.

The Grid serves as a control chart by means of which the quality of growth can be checked. In addition to nutrition, metabolism and the utilization of energy can be watched in the growing child. Recently it has been shown that the Grid may be used in determining the type of patients among whom poliomyelitis is likely to occur. Endocrine disturbances, allergic manifestations, organic disease and constitutional disease produce alterations in the normal growth curve. Even extraneous circumstances, such as social, hygienic, psychologic and domestic conditions may also change the course of the curve.

Moreover, the Grid is recommended for testing purposes in physical education and athletics. Through the association of nutrition with physical ability and performance it is possible to predict reactions of youths to tests of power,

strength, endurance and skill. The athletic director can therefore advise the student to pursue lines of endeavor in which he is most likely to succeed.

The graphic method of plotting the relation of growth to normal health is of great practical use to teacher, nurse, doctor and parent. Such a broad application of this mathematical guide to health has found wide acceptance. This accurate method of observation is available much earlier than the more obvious signs of malnutrition. The Grid therefore can prevent economic waste during the years of growth. Furthermore by its use it is possible to eliminate promptly many health hazards not otherwise detectable.

The Wetzel Grid has been acclaimed not only throughout the United States but in many foreign countries.

CONCLUSION

In surgery, public health, clinical pathology, radiology, animal experimentation and nutrition, Cleveland research workers have added materially to the vast store of medical knowledge. The additions have been of major importance; the use of blood transfusion, the prevention of goiter, the diagnosis of syphilis, the treatment of cancer by radiologic measures, the cause of hypertension, and the determination of malnutrition, all represent pressing problems in current medicine. Doubtless I have overlooked many other contributions but those which have been described represent displays which may be seen in the Museum of the Cleveland Medical Library.

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School Health Programs . . .

Role of Medical Profession Outlined in Report of State Association Committee; Each County Medical Society Requested To Name Committee

IN order that the medical profession can provide leadership and guidance to the efforts which are being carried on in Ohio to develop and maintain improved health education programs and better health services in the schools of the state, the Ohio State Medical Association, by action of The Council, has requested each County Medical Society to establish a Committee on School Health.

A communication on this subject has been sent to the president of each County Medical Society by Dr. A. A. Brindley, president of the State Association.

Dr. Brindley's letter was accompanied by a report of the Committee on School Health of the Ohio State Medical Association which was adopted by The Council on September 19, 1948, and which set forth the reasons for active participation by the medical profession in this field and enumerated certain basic policies for the guidance of County Medical Societies. Later, the State Association committee will distribute suggestions for action programs locally.

Members of the Committee on School Health of the State Association are: Drs. Carl A. Wilzbach, Cincinnati, chairman; Thomas E. Shaffer, Columbus; J. W. Wilce, Columbus; C. W. Wyckoff, Cleveland; Charles T. Atkinson, Middletown; L. A. Hamilton, Athens; T. L. Light, Dayton; R. E. Shell, Van Wert; John F. Miller, Newark; Margaret O'Neal, Zanesville; F. A. Halloran, Springfield; H. B. Thomas, Gallipolis; Russell C. Bane, Chillicothe; and J. M. Painter, Kent.

REPORT OF COMMITTEE

Following is the text of the report which was prepared by the State Association committee and sent to all county societies:

Health is one of the cardinal objectives of modern education.

Every school, big or little, is offered great opportunities to promote the health of its pupils—in fact, of its community.

Realizing this, the Ohio State Medical Association has created a Committee on School Health through which the medical profession of Ohio can provide leadership in the development of sound school health policies and beneficial school health programs in all communities.

By doing so the Ohio State Medical Association will be able to provide active assistance to efforts which are being put forth on a national scale by the American Medical Association.

For years the American Medical Association and the National Education Association have been cooperating on activities in the field of health education. Also, the American Medical Association has worked with other groups in the education profession and with many health organizations interested in promoting better health education and services in the schools. Policies have been developed jointly which serve as a

guide for those who have administrative, teaching or medical duties pertaining to school health activities.

Moreover, the Ohio State Medical Association will be taking an aggressive role in guiding and directing another of the multiple activities designed to improve the physical, mental and emotional health of the generation which will someday be called upon to assume community, state and national responsibilities.

A strong current of public interest in this subject has set in, stimulated by the Selective Service findings of World War II. Although the Selective Service statistics do not present an accurate picture and should not be used necessarily as a basis for health standards which should prevail in a nation at peace, they do sound a warning. The medical profession recognizes this, realizing that the findings did reveal some weaknesses in our health programs. The medical profession has voiced its willingness to give active leadership and assistance to sound methods of eliminating these shortcomings. One of the potent attacks is by improving and strengthening activities dealing with the problems of health among school children.

LOCAL COMMITTEE ESSENTIAL

The degree of leadership attained by the medical profession in Ohio will depend on two things:

(1) Active and intelligent participation by all physicians; (2) organized action and participation on the part of each County Medical Society.

Realizing that participation and action by members of the medical profession in all areas is of paramount importance, the Ohio State Medical Association is requesting each county medical society to establish a local Committee on School Health.

OBJECTIVES

The Committee on School Health of the Ohio State Medical Association and the committees of the County Medical Societies will endeavor to provide leadership, advice and guidance on policies and programs to assure all students in

Ohio's elementary and secondary schools and its colleges and universities:

Healthful school living conditions;

Appropriate health and safety instruction, which will become a part of the student's living experience;

Adequate school health examination services for health protection and improvement;

Healthful physical education and recreational activities;

Teachers and other school personnel who have up-to-date and sound preparation for health responsibilities assigned to them and who are physically and emotionally fit as determined by both regular medical examinations for all school personnel and by continuing efforts to promote good mental hygiene.

GUIDING PRINCIPLES

Successful operation of a school health program, through which the foregoing desirable objectives can be achieved, will depend to a large extent on the following factors:

A. Fullest cooperation on the part of all individuals and groups interested in school health problems, school health services, and health education programs.

B. Formation of and adherence to sound medical and health policies to govern each school health program.

C. Direct supervision and guidance on the part of members of the medical profession over each school health program.

D. Proper administration and coordination of all activities which constitute the school health program.

E. Selection of competent personnel in the operation of the program.

Most of the activities making up a school health program involve medical policies and procedures. Therefore, it is important that members of the medical profession be called upon to participate; that they participate, directly and in an advisory capacity. This applies to both state and local programs.

RECOMMENDATIONS

Maintenance of a proper relationship between a school health program, state or local, and the medical profession, state or local, is essential. This can be achieved if the following recommendations are carried out:

1. State agencies which are engaged either singly or jointly in promoting school health programs in Ohio's schools and colleges should make full use of the facilities, services and counsel offered by the Ohio State Medical Association through its Committee on School Health. Adequate medical representation on the policy-making bodies and advisory committees of these agencies is imperative.

2. Universities and colleges in Ohio which provide training for health education teachers and conduct health programs for their student body should make use of the services and assistance which can be provided by the local medical society school health committee, as well as by the Committee on School Health of the Ohio State Medical Association.

3. Each elementary and secondary school system which has a health program, or contemplates starting one, should seek and receive the support and guidance of the school health committee of the local medical society. The

medical society should be adequately represented on the local school health advisory council, should one be organized. The advisory council should look to the medical society's committee for expert advice on all medical and health problems and activities. The county society committee might be used as a sub-committee of the advisory council.

4. The County Medical Society, with the Committee on School Health as its official spokesman, should be prepared to cooperate in every possible way with local school authorities and personnel engaged in the operation of the school's health program, and with public health departments which are responsible for school health services. Also, the medical society should be prepared to cooperate with agencies and organizations in the community interested in the development and success of the program and to give its support to laws providing for health and sanitary protection for the school child.

5. The County Medical Society and its Committee on School Health should look to the committee of the State Association for suggestions and advice whenever the occasion arises.

6. So far as practical, the administration and coordination of health and medical services, and health education activities, in each school should be under the leadership and control of a doctor of medicine. However, in event a physician possessing administrative ability and experience and training in the technics of preventive medicine and health education is not available, necessitating the appointment of a non-medical administrator or coordinator, it is especially important that the closest cooperation between him and the County Medical Society's committee on school health should be established and maintained. Frequent and frank discussions of program policies and operations should be arranged.

7. There are numerous questions on which the school health administrator will want the advice and suggestions of the committee of the local medical society. For example: (1) Standards for safety and sanitation; (2) health and medical supervision of school personnel; (3) standards for the school food service; (4) content of school health courses and the value of the teaching material used; (5) handling of medical emergencies in the school; (6) prevention and control of communicable diseases; (7) health counseling; (8) form and maintenance of health and medical records; (9) conduct of periodic physical check-ups; (10) utilization of the time and services of the school physician; (11) use of consultants, especially for examination of handicapped or retarded children; (12) precautions and protective measures for play and physical education and in athletic programs; (13) provisions for meeting the needs of handicapped pupils; (14) qualifications of personnel used in health education; (15) method of regular medical examinations for all school personnel.

8. A close relationship should be established between the County Medical Society's committee and all school personnel engaged in health education and physical education. Joint meetings should be arranged for the discussion of such questions as: (1) Individual and adapted physical education programs; (2) classification of pupils for physical education activities; (3) authenticity and value of teaching material; (4) methods of presenting the subjects to pupils; (5) protective measures for school athletes; (6)

means for controlling the "medical excuse" problem in physical education; and similar subjects.

9. State-wide, and locally, the medical profession should cooperate with and be prepared to advise teacher training institutions in their efforts to prepare teachers for health education and physical education.

10. Medical schools in Ohio, and elsewhere, should give serious consideration to providing additional training to medical students on such subjects as: (1) Relation of the practicing physician to the schools and the community; (2) the work of the school physician; (3) the physiology of exercise and the proper function of physical education in the life of the child; (4) the value of and need for more preventive and public health services; and similar subjects.

11. State and local conferences of physicians, public health and school nurses, teachers, and others interested in school health problems and programs should be held frequently for the purpose of discussing questions of mutual interest, exchanging experiences, evaluating existing programs, studying new developments, etc.

12. All concerned with and interested in achievement of the objectives already listed should endorse by thought and action the belief that "the technique of thinking together, working together, and planning together to develop the best plan for united action in a given program, with each participant understanding his responsibilities in relation to the work of others, can be used successfully in solving school health problems throughout the country."

ONLY A BEGINNING

This initial statement by the Committee on School Health is only the first step in the development of good school health programs throughout Ohio. It was prepared primarily for the information of County Medical Societies, to awaken them regarding the problem and to stimulate them into action. The first action should be the appointment of a committee on school health.

In the near future, the Committee on School Health of the Ohio State Medical Association intends to develop a minimum, specific program which can be used by any County Medical Society and the school authorities of the county as a basis for the inauguration of a local school health program.

The third grant made this year by The Research Council on Problems of Alcohol will go to the Chicago Committee on Alcoholism. The amount will be about \$5,000. Other grants included \$30,000, for the second year of a five-year project, to Cornell University Medical College of the New York Hospital, and \$20,000 to New York University College of Medicine-Bellevue Hospital.

The Federal Communications Commission authorized Telanserphone, Inc., New York, to build a radio station for broadcasting code numbers assigned to doctors who would carry small radio receivers. The code number would be repeated over the air until the doctor being sought reported to headquarters by telephone.

General Practitioners Plan National Meet in Cincinnati, March 7-9

Eighteen outstanding medical teachers have been selected by the Program Committee for the first Annual Scientific Assembly of the American Academy of General Practice to be held in Cincinnati, at the beautiful Netherlands Plaza next March 7, 8, and 9. The names of the essayists and their subjects will be announced later.

On September 15 the Executive Committee of the Board of Directors, composed of President Paul A. Davis, Akron, Dr. E. C. Texter, Detroit, and Dr. U. R. Bryner, Salt Lake City, met with the Program Committee and the members of all special committees concerned with preparations for the Assembly in Cincinnati to go over all preliminary details for the meeting. Doctors Davis and Texter are co-chairmen of the Program Committee. Other members are Dr. F. G. Benn, Minneapolis, Dr. R. C. McElvain, St. Louis, and Dr. J. P. Sanders, vice-president, of Shreveport, Louisiana.

All members of the Committee on Local Arrangements were present for the joint meeting of the committees. Dr. Joseph Lindner, Cincinnati, is chairman of the Committee on Local Arrangements. He has appointed Dr. Arthur N. Jay, Cincinnati, to be chairman of the Subcommittee on Registration.

Dr. E. Clarkson Long, Detroit, is chairman of the Committee on Technical Exhibits. Indications are that the leading pharmaceutical and equipment manufacturers of the country will be represented in the technical exhibit.

Mrs. Joseph Lindner, Cincinnati, has been made chairman of the Ladies Entertainment Committee. A separate registration desk and a hospitality desk will be maintained for the ladies and a series of pleasant social functions are being planned for them.

The Congress of Delegates will meet at 10:00 a. m. on Sunday, March 6, preceding the Assembly and again, for its second session, on Tuesday afternoon.

Arrangements have been made to accommodate more than 2,000 members and their wives. Non-members of the Academy may attend the Assembly as guests on payment of a registration fee of \$5.00. Only Doctors of Medicine may register. There will be no registration fee for members. Banquet tickets will be sold at \$5.00 per plate.

Members wishing to make reservations now may do so by addressing the Chairman, Subcommittee on Hotels, American Academy of General Practice, Dixie Terminal Building, Cincinnati 2, Ohio.

Action on Nursing Shortage . . .

Council Approves Recommendations of A.M.A. Special Committee and Acts To Implement Nation-Wide Plan As It Relates to Local Situation

POSITIVE steps which can be taken to relieve the critical shortage of nurses were endorsed by The Council of the Ohio State Medical Association on September 19 when, on recommendation of the Committee on Education, it approved the progress report and recommendations of the special committee of the American Medical Association which is studying the nursing problem on a nation-wide basis. The Council further approved a recommendation of the Committee on Education that the medical profession in Ohio support practical activities to have the A. M. A. suggestions put into effect in Ohio.

The A. M. A. committee favored the following steps: (1) That all nurses be urged to fill in to relieve the immediate emergency; (2) that two classes of nurses be trained and recognized, namely professional nurses and trained practical nurses; and (3) that the economic situation as it exists among nurses be corrected, especially in regard to providing social security, retirement plans and appropriate remuneration.

The A. M. A. committee report was approved by the House of Delegates of the American Medical Association at the June meeting in Chicago.

Members of the O.S.M.A. Committee on Education are: Drs. Carl A. Wilzbach, Cincinnati, chairman; J. Edwin Purdy, Canton; J. L. Webb, Nelsonville; Thomas E. Rardin, Columbus; and Edwin P. Jordan, Cleveland.

Following is the text of the report of the A.M.A. special committee which The Council approved:

Following the vote of the House of Delegates at the Annual Session in Atlantic City, Dr. E. L. Bortz, the President of the American Medical Association, appointed a committee of five to study the nursing problem in the United States. The members of the committee are Drs. Warren F. Draper, Howard K. Gray, Leland S. McKittrick, Donald W. Smelzer and Thomas P. Murdock. The Committee made a report of progress at the Interim Session in Cleveland in January, 1948.

Your committee has gone into the matter exhaustively and has explored all of the available sources of information. During the course of the study, conferences have been held with representatives of the American Hospital Association, the American College of Physicians, the American College of Surgeons, the American Nurses Association and various other nurses' organizations.

PRESENT SHORTAGE

We estimate that about 400,000 nurses will be required to care properly for the American people in 1949. This estimate is based on figures obtained from "Facts About Nursing, 1946 and 1947," and from the report of the President's Commission on Higher Education.

In 1940, 38,000 students were admitted to training schools; in 1941, 41,397; in 1942, 47,500;

in 1943, 53,074; in 1944, 67,051; in 1945, 57,000; and in 1946, 30,899. It will be seen from this that during the period of the nurse cadet program the number was at an all time high. Immediately after the war was over the number dropped about 50 per cent. This may be explained on the basis of patriotism or stipend—probably the former.

It is estimated that there are about 342,737 nurses now available. A bulletin issued by the Women's Bureau of the U. S. Department of Labor indicates that 550,000 nurses will be required to care for the American people in 1960 if current standards of nursing are maintained. It also states that to accomplish this 50,000 nurses must be graduated each year from 1951 to 1960. The largest number ever graduated was 44,700 in 1947. This was the graduating class that entered training schools in 1944 with an admission number of 67,051. The report of the Bureau further states that "this is a realistic appraisal of possible attainment in a given period rather than what is ideally desirable." To obtain what is described as "ideally desirable" would require twice this number. These are staggering and alarming figures and tell American medicine a story of what is before it in the years to come.

NEED VARIES

There is one ray of hope before the committee. A questionnaire was sent, by the American Hospital Association, to 3,800 member hospitals in 1947. Two thousand, three hundred and seventy-six replied. Thirty-seven per cent of these replied that they did not need more nurses. The New England area was in greatest need.

The committee has studied the problem under three headings: (1) immediate relief, (2) proposed

training for all grades of nurses in the future, and (3) the economic situation.

EMERGENCY MEASURE

1. Regarding the first it has recommended that retired nurses, including married nurses, be requested to fill in during the emergency. Through the efforts of Dr. W. W. Bauer and with the generous cooperation of the National Broadcasting Company and the Advertising Council, a great deal of publicity has been given this subject. Many editorials have appeared in *Hygeia* and state and county medical journals stimulating doctors to aid in recruitment of student nurses and urging retired nurses to return to the fold. Personnel trained on the job have been advised and used to supplement nursing services. Trained practical nurses under supervision are being used. Hospital administrators have been requested to use nurses only in nursing duties and to assign other work to auxiliary personnel. It is the feeling of hospital administrators and directors of nursing schools that the situation has begun to show improvement and that it is easier now to obtain nurses in various grades than it was one year ago. The Hospital Career Campaign for the recruitment of student nurses for 1948 gives promise of an increased student nurse enrollment.

TWO CLASSES

2. Under the second heading, which relates to the proposed training of all grades of nurses in the future, your Committee is prepared to make definite and concrete recommendations. We have investigated and studied carefully the question of bedside nursing and the required training for this grade of nurse. We recommend two main classes of nurses: (A) professional nurses, and (B) trained practical nurses.

(A) Professional Nurse.—This group is to be subdivided into (a) nurse educators and (b) clinical nurses.

(a) Nurse educators are to be those with collegiate training and others who have shown an aptitude for teaching, administration and supervisory positions. These are to fill the positions of directors of nursing schools, teachers, department and clinical supervisors, public health nurses, etc. The training for these nurses should be collegiate training before entering the nursing field or combined collegiate and nursing training.

(b) The clinical nurse is to be comparable to the present day general duty or private duty nurse. Selected clinical nurses with an aptitude and ability for teaching may well be considered for some of the subordinate teaching positions. We recognize that there are many duties to be assigned to this grade of nurse which could not be filled by the trained practical nurse. We recommend that the course of training for the clinical nurse be reduced to two years.

TRAINED PRACTICAL NURSES

(B) The Trained Practical Nurse.—Your committee has underscored the word trained. Unfortunately it seems to the committee, the term "practical nurse" bears the implication of no training. However, the term has already been written into the statutes of several states and a change of the name would be difficult. At the same time the committee feels that the name is not of major significance, but does feel, however, that it is very important that uniform standards

of training and duties be established across the country. For this group your committee recommends one year of training made up of three months theoretical and nine months practical training. This can be accomplished completely in a hospital, or the three months theoretical training may be taken under a department of education and the nine months training in an acceptable hospital. Your committee feels that this group of trained practical nurses, under proper supervision of professional nurses and medical staff, will be able to do much of the routine bedside nursing now being done by professional nurses, but that the more delicate and intricate duties must be left to the professional nurse. We believe that sufficient bedside nursing care can be obtained economically and efficiently if the professional nursing staff is augmented by trained practical nurses. Provision should be made, and credits allowed, in selected cases, toward training for advancement from the grade of trained practical nurse to the grade of clinical nurse.

ECONOMIC RELIEF

3. The last or economic problem presents certain features which should be corrected. Your committee urges that steps be taken to provide social security and retirement plans for all nurses. This is advised from the business and moral points of view. We also recommend that hospitals adopt a definite personnel policy, for all institutional nurses, with a view toward making salaries, hours, sick leave and vacations comparable to other fields of endeavor for women with equivalent education and training.

The committee recommends that the cost of essential special nursing care, to the patient, be covered by prepayment nursing plans or be tied into prepayment hospital and medical plans, if practicable.

ACTION AT ATLANTIC CITY

The committee feels that the nurses innocently erred in their action in Atlantic City in 1946 when they voted to have their state organizations act as bargaining agents for them. They are members of a noble profession. They do not need bargaining agents. The term bargaining agent carries with it the implication to strike even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere, any time. They are dealing with that most priceless possession—life itself. It is hoped that the nurses will correct this in the near future.

A permanent Conference Committee made up of representatives of the American Nurses Association and other nurses' organizations, the American Hospital Association and the American Medical Association has been formed. The duties of this committee will be to study the problems common to all. Nursing problems are the most urgent and important at present. This committee might well be used to adjust any differences that any of the groups might have.

The committee wishes to thank Dr. E. L. Bortz, the President of the American Medical Association; Dr. Elmer Henderson and the Board of Trustees; Dr. Morris Fishbein, the Editor of *The Journal*, and the representatives of the American Hospital Association for their cooperation and aid in this study. The representatives of the various nurses' organizations have been very helpful to the committee. They are anx-

ous to have this whole nursing problem solved and have cooperated fully. The committee expresses its gratitude for their aid.

SUMMARY

And so we end, at least for the present, the study of the nursing problem and summarize it as follows:

1. It is estimated that about 400,000 nurses will be required to care for the American people in 1949. The committee feels that this can be accomplished.

2. Labor Department statistics indicate that about 550,000 nurses will be needed in 1960. To accomplish this about 50,000 nurses must be graduated each year between 1951 and 1960. This can be accomplished by the generous cooperation of all concerned.

3. The committee has proposed measures for the relief of the present situation and feels that much has been accomplished.

4. The committee recommends that changes be made in the present method of training nurses; that in the future nurses be made up of two main groups—the professional nurse and the trained practical nurse. The requirements, duties, and courses of training of both main groups have been outlined.

5. The economic situation has been reviewed and methods of correction suggested.

6. A permanent Conference Committee has been formed, made up of representatives of the American Nurses Association, the American Hospital Association and the American Medical Association.

7. The committee believes that this permanent Conference Committee will be the organization to implement your committee's recommendations and the recommendations that come from other interested groups.

Respectfully submitted,

Thomas P. Murdock, Chairman,
Warren F. Draper,
Howard K. Gray,
Leland S. McKittrick,
Donald W. Smelzer.

Ohio Deaths and Births Show Sharp Rise in 1947

The number of deaths in Ohio, after declining gradually from 1943 through 1945 and rising slightly in 1946, rose sharply during 1947, according to the Annual Vital Statistics Report released recently by the Ohio Department of Health.

The number of deaths for the five years were: 1943—82,030; 1944—79,868; 1945—77,625; 1946—77,839; and 1947—82,007. The number of deaths from four leading causes during 1947 were: Diseases of the heart, 26,333; cancer, 10,994; cerebral hemorrhage, 8,378; and nephritis, 4,676.

The numbers of births reached the phenomenal high of 197,296, or a rate of 25.4 per 1,000 population. Other comparative rates were: 1910—21.1; 1920—21.4; 1930—17.6; and 1940—16.6.

Second District Officers

Officers of the Second Councilor District of the Ohio State Medical Association elected at the annual meeting on September 29 in Springfield are: Dr. Forrest E. Lowry, Urbana, president; Dr. Merrill D. Prugh, Dayton, vice-president; Dr. George A. Woodhouse, Pleasant Hill, secretary; and Dr. William H. Hanning, Dayton, treasurer.

Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association, was a guest at the meeting. He also addressed a luncheon meeting of the district Woman's Auxiliary at Hotel Shawnee on the subject, "A New Medical Cooperative, the Woman's Auxiliary."

More than 120 persons were present for the district meeting.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since September 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ATHENS COUNTY

Eleanora Schmidt, Athens

CLARK COUNTY

William H. Crays, Springfield

R. Hugh Mabry, Springfield

R. P. McCulloch, Springfield

CUYAHOGA COUNTY

John F. Brennan, Cleveland

Everett P. Coppedge, Jr., Cleveland

Jack B. Garlin, Bedford

George G. Goler, Cleveland

Robert C. Heskett, Cleveland

LeRoy J. Hyman, Cleveland

Herman F. Inderlied, Cleveland

Harry C. Konys, Cleveland

Samuel H. Lerner, Cleveland

James E. O'Hare, Cleveland

Ralph J. Pelegrin, Cleveland

Harold B. Riser, Rocky River

Russell P. Rizzo, Cleveland

Richard C. Roesemann, Cleveland

Walter S. Sellars, Cleveland

John Joseph Smith, Cleveland

Sewell K. Starcke, Cleveland

Manly Utterback, Cleveland

Dean C. Varney, Cleveland

Charles A. White, Cleveland

HAMILTON COUNTY

Robert G. Armstrong, Cincinnati

Harry J. Bingham, Cincinnati

Gustav Eckstein, Cincinnati

Forman Friend, Cincinnati

Sylvan A. Golder, Cincinnati

Chapin Hawley, Cincinnati

C. Rowell Hoffmann, Cincinnati

Curwood R. Hunter, Cincinnati

Paul N. Jolly, Cincinnati

Richard F. Kelly, Cincinnati

William L. McGowan, Cincinnati

Carl F. Schilling, Cincinnati

LORAIN COUNTY

Theodore E. Finegan, Elyria

PORTAGE COUNTY

Edward P. Reese, Windham

ROSS COUNTY

R. P. Giesler, Chillicothe

Robert E. Swank, Chillicothe

SENECA COUNTY

Henry L. Abbott, Tiffin

SUMMIT COUNTY

Glenn V. Hough, Akron

Norman E. Wentsler, Jr., Akron

James M. Whitworth, Cuyahoga Falls

Aubrey S. Willacy, Akron

TUSCARAWAS COUNTY

Thomas F. McCough, New Philadelphia

Red Cross Blood Banks . . .

Council Approves Principles of A. M. A. Which Advocate Control Within Counties With Arbitration of Differences at State Level

THE set of principles in regard to blood banks as approved by the House of Delegates of the American Medical Association was adopted and approved by The Council of the Ohio State Medical Association at its meeting on September 19 as a working basis for establishment and control of blood banks in Ohio.

The principles were outlined by a reference committee of the A. M. A. in a report approved by the House of Delegates at the national meeting in Chicago.

The principles endorsed by The Council are summarized as follows:

"First, local control must be in the county medical society.

"Second, the local medical society should be the initial contact in the contemplation of inauguration of a new blood bank.

"Third, no publicity nor news releases shall be released except by mutual consent of the local county medical society and the local chapter of the American Red Cross.

"Fourth, differences of opinion in establishing or operation of a blood bank in either administrative or technical detail shall be arbitrated at state levels by joint committees from the state medical society and the American Red Cross."

The report of the A.M.A. reference committee and endorsed by The Council is as follows:

Your reference committee had referred to it that portion of the report of the Board of Trustees in regard to blood banks as well as several resolutions in regard to the same subject. It has reviewed and studied all carefully and held several committee meetings with excellent attendance at which every man present had the opportunity of free discussion. Your reference committee feels that it is unnecessary to consider each resolution individually and much more important to view the problem on a broad national basis and attempt to outline some general principles in regard thereto.

APPROVAL IN PRINCIPLE

Realizing the possibility of a national emergency requiring large amounts of blood in the treatment of civilian and military casualties and realizing the unique position of the American Red Cross in disaster relief, your committee is of the opinion that no change should be made at this time in the "approval in principle" of the participation of the American Red Cross in the national blood program voted at the Interim Session in January, 1948.

However, your committee would call attention of the House to the fact that long before the Red Cross entered this field of medical practice many previously established blood banks had been operating successfully and adequately under strictly local supervision and had rendered invaluable services to the community. To disturb such independent local units would, in the opinion of your committee, be unwise and disastrous, for they have repeatedly demonstrated their ability to meet local and regional needs. Furthermore, they have demonstrated the practicability of free enterprise and local initiative.

From the testimony presented at the several hearings before your reference committee, it is quite evident that there has been confusion and

misunderstanding between local chapters of the Red Cross and the medical profession at local levels.

PRINCIPLES OUTLINED

It is the opinion of your reference committee that the "Approval in Principle" be construed as follows:

First, local control must be by the county medical society.

Second, the local medical society should be the initial contact in the contemplation of inauguration of a new blood bank.

Third, no publicity nor news releases shall be released except by mutual consent of the local county medical society and the local chapter of the American Red Cross.

Fourth, difference of opinion in establishment or operation of a blood bank in either administrative or technical detail shall be arbitrated at state levels by joint committees from the state medical society and the American Red Cross.

CONTINUED COOPERATION

Recognizing the professional ability of the physicians constituting the Advisory Committee of the national American Red Cross and the efforts they have made in behalf of this program as well as the efforts of a similar committee approved by the House of Delegates of the American Medical Association in January, 1948, your reference committee feels that this intimate cooperation should be continued. However, it is also the feeling of your committee that in a program of such national importance, even greater effort and cooperation is needed in the future to attain desired objectives. Accordingly, it recommends that the committee of the American Medical Association be enlarged to nine members with definite instructions to meet at stated intervals at the call of either the chairman of our committee or that of the Red Cross. The committee of the American Medical Association

State Medical Board in Session



The State Medical Board of Ohio is shown as it met on October 5 in the Board offices, 21 W. Broad St., Columbus. Clockwise around the table are: Mr. Joseph T. Ford, assistant attorney general and legal advisor to the Board; Dr. J. N. McCann, Youngstown; Dr. Thomas H. George, Cleveland; Dr. J. H. J. Upham, Columbus; J.O. Watson, D. O., treasurer, Columbus; Dr. Dwight J. King, president, Findlay; Dr. Ralph B. Taylor, Columbus; Dr. C. W. Waggoner, vice-president, Toledo; Dr. W. M. Hoyt, Hillsboro; and Dr. H. M. Platter, secretary, Columbus.

so appointed shall report to the House of Delegates at each session.

Your reference committee feels that any provision of free medical service or supply to everyone without regard to ability to pay is in opposition to the principle that it is the responsibility of an individual to assume the obligations of medical expense just as he does for other living expense. Your reference committee deplores the use of the term "free blood" in the publicity of the American Red Cross.

Respectfully submitted,

Edwin S. Hamilton, Chairman,
Charles R. Rountree,
J. H. Moore,
Thomas M. Brennan,
Claude R. Keyport.

Elks Plan Spastic Program

A program to educate parents in the detection of spastic paralysis recently was mapped by the Ohio Elks Association, and according to announcement will include the making of a narrated movie depicting all aspects of the condition, and possibly establishment in Columbus of a medical center for physiotherapy training.

Plans are for the movie to be made at the Franklin County Society for Crippled Children with Dr. Edward J. McCormick of Toledo, past grand exalted ruler of the national Elks Lodge, as narrator.

State Medical Board Lays Plans For Dec. 13-15 Examinations

Adoption of questions for the December 13-15 examination for licenses to practice in Ohio were considered at the meeting of the State Medical Board of Ohio on October 5.

After hearings, the Board revoked the certificate of mechanotherapist, Carl Botkin of Akron, and suspended indefinitely the certificate of Jacob Krohmer, Cleveland, to practice mechanotherapy, massage and Swedish movement.

It was announced that the case of Mayer Nearing, Cleveland, mechanotherapist, chiropractor and electrotherapist, whose certificate the Board revoked at a previous meeting, had been appealed to the Common Pleas Court of Cuyahoga County.

At the September meeting of the Board, the license of Julius Rabb, M. D., of Cleveland, was revoked after he was found guilty on a charge of criminal abortion.

The certificate of Albert B. Humphrey, Columbus, mechanotherapist, was suspended for six months.

Preliminary to placing into effect new regulations, the Columbus Health Department recently completed a communicable disease examination of more than 14,000 food handlers.

Proceedings of The Council . . .

Much Business Transacted At Fall Conference; Policies on Questions of Vital Interest Adopted; Plans For 1949 Meeting Are Adopted

THE Fall meeting of The Council of the Ohio State Medical Association was held at the Granville Inn, Granville, Ohio, Friday, Saturday and Sunday, September 17, 18 and 19, 1948. All members of The Council were present except the treasurer, Dr. H. P. Worstell, Columbus. Those attending as guests of The Council were: Dr. Louis G. Herrmann, Cincinnati, Chairman of the Committee on Scientific Work; Dr. Carl A. Wilzbach, Cincinnati, Chairman of the Committee on Education; Dr. C. E. Hufford, Toledo, Chairman of the Committee on Cancer; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; Doctors G. A. Woodhouse, Pleasant Hill, Wm. M. Skipp, Youngstown, and C. C. Shurburne, Columbus, Ohio Delegates to the American Medical Association; Mr. Charles H. Coghlan, Columbus, Executive Vice-President, Ohio Medical Indemnity, Inc.; Secretaries Charles S. Nelson and G. H. Saville; Mr. Hart F. Page, Assistant Director of Public Relations; and Mr. R. Gordon Moore, Assistant Managing Editor of *The Journal*.

Dr. Brindley presided at the business sessions of The Council, four of which were held during the three-day period.

On motion by Dr. Swartz, seconded by Dr. Messenger, and carried, the minutes of the meeting of The Council held on June 6, 1948, were approved.

NEW MEMBERSHIP RECORD

The Executive Secretary reported on membership as follows: Total membership as of September 17, 1948, 7,204, of which 24 are military members; compared to a total membership of 7,106 as of December 31, 1947. It was announced that the present membership of the Association is the largest in its history.

A report was presented by the Executive Secretary on the financial condition of *The Ohio State Medical Journal*. This revealed that, because of an increase in publishing costs and a slight decrease in advertising receipts, it will be necessary for the Association to increase its allowance to *The Journal* in order for *The Journal* to meet its expenses for the calendar year 1948. Following a discussion, on motion by Dr. Rutledge, seconded by Dr. Dixon, and carried, an additional allowance of \$5,000 from State Association funds for this purpose was authorized.

The Executive Secretary reported on the necessity for filling a stenographic position in the Columbus Office due to the resignation of Mrs. Grace Hune. He was authorized to secure a

suitable replacement, on motion by Dr. Clodfelter, seconded by Dr. Davis and carried.

Members of The Council then presented reports on visits to and activities in their respective districts.

PLANS FOR 1949 MEETING

Dr. Herrmann and the Executive Secretary presented a report on preliminary arrangements for the 1949 Annual Meeting, which will be held at the Neil House and the Deshler-Wallick Hotel, Columbus, April 19, 20, 21 and 22. Dr. Herrmann pointed out that a meeting of the Committee on Scientific Work with the Section Officers and Program Committees would be held at the Columbus Office on Sunday, September 26, at which additional arrangements would be worked out.

It was suggested that the evening of Tuesday, April 19, be left open, except for a dinner and business session of the House of Delegates; that the annual banquet be held on Wednesday evening, April 20; and that on the evening of Thursday, April 21, a general session be held to consist of panel discussions on such questions as the medical care program for recipients of aid for the aged, Workmen's Compensation, Veterans Administration, crippled children, etc. On motion by Dr. Clodfelter, seconded by Dr. Bowman, and carried, these recommendations were approved.

A sample of a scientific award certificate was presented and, on motion by Dr. Clodfelter, seconded by Dr. Swett, and carried, the Executive Secretary was authorized to have such certificates made and framed for awarding to the winners in the 1948 Scientific Exhibit and future exhibits. The same motion recommended that a suitable card be prepared, after the winning exhibits have been selected, to be posted in the booth of the respective winners.

Dr. Wilzbach presented a report, on behalf of the Committee on Education, regarding the Postgraduate Seminars to be held on October 21, October 27, and November 3. Attention was called to the detailed programs for these meetings, published in the September issue of *The Journal*.

NURSING PROBLEM

Dr. Wilzbach then presented a recommendation from the Committee that The Council approve the report and recommendations of the special committee of the American Medical Association, which is studying the problem of the short-

age of nurses, and which was adopted by the House of Delegates of the A.M.A. at the June meeting in Chicago; and that The Council take whatever steps would seem advisable to implement in Ohio the recommendations contained in the A.M.A. report. The report of the A.M.A. was discussed, copies having been distributed to members of The Council in advance of the meeting. On motion by Dr. Clodfelter, seconded by Dr. Davis, and carried, the recommendations of the Committee on Education on this matter were approved, and the Executive Secretary instructed to prepare copies of the report for distribution. (See page 1136 for text of A. M. A. report.)

INTERN TRAINING

A report from the Committee on Education on the question of internships and residencies in general practice was submitted by Dr. Wilzbach, reading as follows:

"The Committee on Education of the Ohio State Medical Association has been requested to consider various resolutions and communications concerning hospital residencies for general practice. Some residencies of this nature have been established but several broad and difficult problems are involved.

"The following memorandum concerning this matter was prepared prior to the meeting of the American Medical Association in June of 1948:

1. The need for more hospital internships or residencies adapted to the physician planning to engage in general practice has received much attention.
2. There is widespread criticism both within and without the profession to the effect that specialization in medicine starts too early and frequently results in undesirable narrowness in outlook.
3. Many approved internships do not actually provide rotation in or experience with all the major branches of medicine.
4. There is a serious disparity between the number of approved internship vacancies and the number of medical school graduates available to fill these positions. The Council on Medical Education and Hospitals of the American Medical Association estimates that in 1948 there will be 9,118 approved internships and 5,716 graduates of medical schools.

"The criteria as to what will constitute an approved internship are established by the Council on Medical Education and Hospitals. The Council might, therefore, be urged to establish criteria for approval of internship which will involve rotation in or experience with Internal Medicine, Obstetrics and Gynecology, Pediatrics, and General Surgery as a minimum number of medical branches. If this were done, it would help to solve some of the questions raised in 1, 2, and 3 mentioned above. It might be recommended further that the Council on Medical Education and Hospitals encourage the establishment of second year internships

for general practitioners. During this year concentration in one of the major branches for not more than six months should be permissible. A suitable form of recognition for an additional year for internship training for general practitioners should be devised, and there is no reason why this could not be done.

"The adoption of these suggestions would mean that there would be no differentiation in training until after the first year of internship between the physician who is planning to engage in general practice and the one who is going to devote himself to a medical or surgical specialty. Because a large number would undoubtedly plan to take a second year of internship, the gap between the number of approved internships and the number of physicians available to fill these positions would probably be narrowed.

"There is a danger that the encouragement of an additional year of internship prior to engaging in general practice would be considered as further delaying the entrance of physicians into general practice and as introducing just one more requirement. From the standpoint of the medical profession, this valid criticism could be met by urging the medical schools to accept students on the average earlier than they now do by making acceptance to medical school after two years of college training the rule rather than the exception."

"At the meeting of the House of Delegates of the American Medical Association in June, 1948, a report from the Committee on Intern Placements was presented, a portion of which has a direct bearing on this problem. This report stated in part:

"Secondly, in the interest of promoting general practice and better to prepare a physician to choose a specialty, we recommend that all specialty boards require at least one year of approved rotating internship before allowing a physician to start his specialty training.

"Thirdly, we recommend that an approved rotating internship shall be of one or two years' duration; should include an educational training program in medicine, both organic and functional; obstetrics, pediatrics and surgery with especial emphasis on diagnosis under the supervision of a qualified educational director of interns. More of these internships should be for a term of two years. The specialty boards should be requested to give credit toward certification for work in their respective fields during the second year.

"Fourthly, we recommend that hospitals at present approved for internship should be reappraised on the basis of their educational program for interns.

"Fifth, we recommend that any hospital which does not provide an adequate educational training program for interns may be approved for general residencies for graduates who have completed an approved, rotating internship of at least one year.

"Lastly, being mindful of the difficulties involved because of the differences in medical school requirements, the differences in state laws, the differences in requirements of specialty boards and the differences in hospital regulations and organizations, we recommend that the Council on Medical Edu-

cation and Hospitals be and it is hereby instructed immediately to begin implementation of these recommendations and to report at the next session of the House of Delegates the progress toward accomplishment of each of these recommendations.' ("Report of Committee on Intern Placements." J.A.M.A. 137:883 (July 3) 1948.)

"There is a close parallelism between the report of the A.M.A. Committee on Intern Placements and the memorandum previously noted. This is evidence of recognition in many places of a similar problem. The problem appears to be national in scope. The Committee on Education, consequently, recommends the transmissal of this material to the Council on Medical Education and Hospitals with an accompanying letter indicating that the Ohio State Medical Association believes the questions raised to be of great importance and urgency."

On motion by Dr. Dixon, seconded by Dr. Swett, and carried, the foregoing report and recommendations of the Committee on Education were approved.

POLL OF PHYSICIANS SUGGESTED

Dr. Wilzbach reported that the Committee on Education had considered the possibility of sending a questionnaire to physicians in practice, asking them to comment on what they considered deficiencies in the present-day education and to offer recommendations on how present-day medical teaching and instruction might be improved. He stated that the Committee arrived at the conclusion that the problem was more than a state problem and recommended that The Council suggest to Council on Medical Education and Hospitals of the A.M.A. that a survey of physicians in practice on this subject should be carried on in connection with the present survey of medical education being undertaken by the A.M.A.

On motion by Dr. Clodfelter, seconded by Dr. Dixon, and carried, the report and recommendations of the committee on this subject were approved.

SPECIALTY BOARD QUESTION

Dr. Wilzbach reported that the Committee on Education is preparing a report for the House of Delegates at the 1949 Annual Meeting with respect to the suggestion that the specialty boards require a physician to have had at least five years in general practice before entering specialty training. It was pointed out that this matter had come before the House of Delegates at the 1948 meeting of the State Association and had been referred to the Committee on Education for study and recommendation. There was an extensive discussion of the subject by members of The Council and Dr. Wilzbach was requested to convey to members of the Committee the sentiments expressed by various Councilors before the final report of the committee

is drafted for consideration by the House of Delegates in April, 1949.

The questions of selection of medical students and the possibilities for increasing enrollment in medical schools were discussed. On motion by Dr. Clodfelter, seconded by Dr. Rutledge, and carried, the Committee on Education was requested to give attention to this subject and to report its findings and recommendations to The Council at some future meeting.

RURAL HEALTH ACTIVITIES

A report of the Committee on Rural Health was presented by Dr. Mundy, a member of The Council and Chairman of that Committee. Reference was made to articles appearing in recent issues of *The Ohio State Medical Journal*, outlining many of the activities of that Committee. Special attention was called to the pamphlet and exhibits on Brucellosis.

The question of having the Ohio State Medical Association sponsor scholarships in medicine for rural youth as a part of the move to try to encourage physicians to practice in rural areas was discussed at considerable length. Without a record vote The Council endorsed the idea but deferred action, requesting the Committee on Rural Health to draft a specific plan for submission to The Council at its December meeting.

REPORT ON HOSPITAL QUESTION

A report of a special committee, consisting of Dr. E. O. Swartz, Cincinnati; Dr. J. Craig Bowman, Upper Sandusky; and Dr. H. M. Clodfelter, Columbus, which had been appointed by the President to study a controversy between the Summit County Medical Society and the Akron Children's Hospital, was presented by Dr. Swartz, reading as follows:

"Your Committee has carefully studied all the data and correspondence submitted to it by the Summit County Medical Society and Board of Trustees of Children's Hospital of Akron. We have had several conferences and have given this controversy much thought and study.

"We realize that, while this affair may have State and National implications, yet it is basically a local issue and should be settled locally by the parties to the dispute. We are impressed with the honesty and sincerity of both groups and note with pleasure that—except for several minor issues—an agreement mutually satisfactory has been reached on all controversial issues except three, namely:

1. 'Section defining (Art. 2 and 3) class of membership. This was not approved because there was not established a Section on General Practice in the Staff and
2. 'The duties of the Emeritus Consulting Staff were limited to acting in an advisory capacity to the Executive Committee of the Staff only.

3. "The disposition of polio and other contagious cases in the hospital."

"We feel that this controversy should be settled by conference locally without resort to press or other publicity or propaganda.

"We feel that, especially at this time, it is imperative that the medical profession present a united front to those who would change our system of free medical enterprise and we fear that the division of the profession into militant minority groups, may be used as the entering wedge by those forces who would destroy our system of medical practice. We deplore the lack of unity which controversies such as this may produce.

"We wish to point out several things to the parties of this controversy.

"First, all progress, all legislation, all reform, is the result of compromise, of give and take, and we feel sure this can be settled in this manner.

"We also respectfully call attention to several actions by medical bodies.

"1. The action of the House of Delegates of the A.M.A. in setting up a Section on General Practice in the A.M.A.

"2. The Council of the O.S.M.A. recommended that a Section on General Practice be set up in every accredited hospital in Ohio. The Council has no desire or intent to interfere in the administration details of hospital management. It has no moral or legal right to attempt to force its recommendations on the hospitals. It is concerned only with helping its members and the profession of Ohio render better service to the public and improve its relations with the hospitals in which the profession works. It will always oppose discrimination against the profession but has no desire to interfere with administrative details of hospitals nor does it want to see interference in purely medical affairs by lay groups.

"3. Resolution of the House of Delegates in Cincinnati in April, 1948, stating that it is their opinion that in Ohio hospitals, purely medical questions should be decided by the Medical Staff and administrative problems be settled by hospital administration and that the Staff should not attempt to settle nor interfere in problems of hospital administration nor the administration to solve purely medical and Staff problems. It is our opinion that the attending medical staff, under proper by-laws, should control its own membership makeup.

"4. Action by both the A.M.A. and A.C.S. establishing minimum requirements for Intern Service.

"We furthermore desire to point out that The Council of the O.S.M.A. is not per se a judicial body and that it has no means at its disposal to enforce its recommendations. It is purely a policy forming body and even if it desired to use police or disciplinary action The Council has no such power. This power is to be exercised at the county level by County Medical Societies. The State Council can recommend but not coerce.

"It seems to us that a Children's Hospital, even though it is a so-called "teaching hospital," is a public general hospital operating within certain age limits, designed to render

the best available medical and surgical care to the children in its area.

"To this end, its Staff should be composed of able and competent physicians, chosen for ability to render good medical care regardless of Board Certification or approval, and such specialists as may be needed to assist in their respective fields when called upon. The object of such a composite staff is the rendering to the community the best medical and surgical care available. A closer cooperation between the able practitioner and the well-trained specialist will improve the quality of service available, and will do away with much of the criticism of the profession.

"No thoughtful Board of Trustees would deprive the community or the hospital of competent general practitioners for it is around the general practitioners that all medical specialism is based. In many communities the teamwork of the G.P. and specialist has brought satisfactory medical care to the sick and in these situations the competent G.P. does not hesitate to make use of the assistance the highly trained specialist can give, when the good of the sick demands such joint action.

"The setting of minimal standards for Intern and Resident qualifications and training have been worked out by both the A.M.A. and A.C.S. and these should be adjusted to meet local requirements and conditions by both Staff and Board.

"Your Committee recommends that if possible, local jealousies, prejudices, and animosities be entirely disregarded and that the By-Laws of the Children's Hospital be so amended as to permit the creation of a Section of General Practice within the Staff of the Children's Hospital of Akron. This is in conformity with resolutions of both the A.M.A. and the O.S.M.A.

"We further recommend that, with a view to preventing discrimination against the profession, and promoting better feeling between Staff and Board of Trustees and rendering better medical service to the community, other matters in dispute be settled by a committee of seven. This committee to consist of three persons chosen by the Board of Trustees and three chosen by the County Medical Society and one chosen by the two groups. The County Medical Society and Board of Trustees are each to agree to abide by the decisions of this committee.

"We hope that by conference, conciliation, compromise, and give and take, all these differences may be resolved and a competent satisfied staff working with a Board of Trustees anxious to provide the best equipped workshop for the staff may produce the highest grade of medical and surgical care obtainable to the sick and suffering in this area.

"We feel that peace and harmony between the Board of Trustees and Staff is an essential to the rendering of high grade medical and surgical care to the community."

On motion by Dr. Swartz, seconded by Dr. Bowman, and carried, the report of the special committee was approved, and the Executive Secretary ordered to send copies to the Summit County Medical Society, the officials of Akron

Children's Hospital, and the officers of the medical staff of such hospital.

PAMPHLET APPROVED

Mr. George H. Saville, Director of the Department of Public Relations, discussed the copy for a proposed pamphlet for the physician's receptionist or secretary, pointing out how she can assist in carrying on and improving the public relations of the physician and the relationship between the physician and his own patients. Members of The Council expressed themselves as believing that the project is desirable, and on **motion** by Dr. Messenger, seconded by Dr. Davis, and **carried**, approved the copy for the pamphlet and authorized the Department of Public Relations to proceed with the publication and distribution of the booklet.

SUGGESTED RADIO PROGRAMS

Mr. Saville reported on correspondence with the Bureau of Health Education of the American Medical Association on the matter of radio programs which would be produced by the American Medical Association and financed by the various state medical societies on a pro rata basis. On **motion** by Dr. Rutledge, seconded by Dr. Swett, and **carried**, Mr. Saville was authorized to continue negotiations with the A.M.A. on this matter and to affiliate with the project if reasonable financial arrangements can be worked out.

SCHOOL HEALTH REPORT

Dr. Wilzbach, reporting for the Committee on School Health, discussed a statement of policy and action prepared by the committee, copies of which had been distributed to members of The Council in advance of the meeting. On **motion** by Dr. Dixon, seconded by Dr. Rutledge, and **carried**, the report and recommendations of the committee were approved. (See page 1133 for text of report.)

OHIO MEDICAL INDEMNITY

Mr. Charles H. Coghlan, Executive Vice-President of Ohio Medical Indemnity, Inc., in attendance by special invitation, presented a detailed report on the activities and condition of Ohio Medical Indemnity, Inc., and on **motion** by Dr. Clodfelter, seconded by Dr. Davis, and **carried**, Mr. Coghlan was congratulated on the excellent report and the report was accepted and ordered filed.

Mr. Coghlan and the Executive Secretary reported on proposals for the organization of a national Blue Cross-Blue Shield Association and a national Blue Cross-Blue Shield Health Service, Inc., to be voted on by the various Blue Cross and Blue Shield plans at a conference at French Lick Springs, Indiana, October 25-28. It was pointed out that copies of the proposals were

received on September 17, too late to be distributed to members of The Council in advance of this meeting. The Council took no action as members had had no opportunity to study the proposals and the time at this meeting would not permit such a study. It was the consensus of members of The Council that the proposal should be carefully studied by the Board of Directors of Ohio Medical and specific instructions should be given to representatives of Ohio Medical on the views of the Board prior to the meeting at French Lick Springs.

NATIONAL EMERGENCY AND SELECTIVE SERVICE

Dr. Sherburne, chairman of the Committee on National Emergency Medical Service, reported on the activities of his committee to date, referring especially to conferences which had been held with Governor Thomas J. Herbert and Adjutant General Chester W. Goble on the question of a proposed medical setup for a State disaster program.

The Executive Secretary presented a communication from the Ohio Selective Service Headquarters, requesting the assistance and cooperation of the Ohio State Medical Association in setting up a State Medical Advisory Board to the State Director of Selective Service and a medical adviser for each local Selective Service Board.

On **motion** by Dr. Davis, seconded by Dr. Swett, and **carried**, The Council voted the cooperation and assistance of the State Association and instructed the Executive Secretary to obtain suggestions from all county medical societies for physicians who would be willing to serve as medical adviser to the local board or boards.

CANCER CONTROL ACTIVITIES

At this point, a brief report was presented by Dr. Hufford, Chairman of the Committee on Cancer, in which he pointed out some of the activities of the Committee and how it is working with the Ohio Department of Health and the Ohio Division of the American Cancer Society.

The Executive Secretary read a letter received from Dr. John D. Porterfield, State Director of Health, asking for the opinion of The Council on a proposal that cancer be made a reportable disease in Ohio. Following a general discussion, during which there was a difference of opinion among members of The Council on the question, the matter was referred to the Committee on Cancer for study, with instructions to prepare a report for consideration by The Council at a future meeting, on **motion** by Dr. Davis, seconded by Dr. Rutledge, and **carried**.

Additional correspondence from Dr. John B. Youmans, Dean of the College of Medicine, University of Illinois, regarding a year book on medicine which would be offered to members of

the Ohio State Medical Association in the form of a supplement to *The Ohio State Medical Journal* or through special subscription arrangements, was read and discussed. On motion by Dr. Clodfelter, seconded by Dr. Davis, and **carried**, the previous action of The Council, rejecting participation in this project, was confirmed.

WORK OF HEALTH COMMITTEE APPROVED

The Executive Secretary presented a report on the activities of the Ohio Committee on Public Health, of which he is chairman, consisting of representatives of 14 or 15 state-wide organizations, the purpose of which is to try to work out improvements in the organization and programs of the State and local health departments. A statement prepared by that committee, setting forth the objectives and immediate activities of the committee, was read and discussed. On motion by Dr. Clodfelter, seconded by Dr. Davis, and **carried**, the report was **approved**.

A communication from Mr. Edison L. Bowers, Chairman of the State Advisory Council, Bureau of Unemployment Compensation, was presented. The letter requested the State Medical Association to name a representative who could meet with a special committee of the Advisory Council, engaged in a study of sick-pay benefits as a part of the unemployment compensation program. On motion by Dr. Davis, seconded by Dr. Messenger, and **carried**, the Executive Secretary was instructed to represent the Association at such conferences.

PLACEMENT OF DISABLED

A request from the Veterans Employment Service of the United States Employment Service, that the Association consider the possibility of carrying on an educational program among physicians on the relationship between the medical profession and the placement of the physically handicapped in industry, was read and discussed. The possibility of arranging for a one-day program on this subject was considered. The matter was referred to the Committee on Industrial Health and Workmen's Compensation for study, on motion by Dr. Bowman, and seconded by Dr. McAfee, and **carried**.

WORKMEN'S COMPENSATION

Communications from several members, requesting the Ohio State Medical Association to endeavor to have the State Industrial Commission increase the fees allowed physicians for home and office visits, were read and discussed. A report from Dr. Worstell, chairman of the Committee on Industrial Health and Workmen's Compensation, regarding conferences which had been held on this matter, was presented. On motion by Dr. Rutledge, seconded by Dr. Swartz, and **carried**, the Committee was instructed to hold a formal conference with the Industrial

Commission on this matter at the earliest possible date, at which the recommendations of The Council drafted on December 14, 1947, should be presented as a basis for discussion.

GENERAL PRACTITIONER'S AWARD

A communication from the American Medical Association, outlining new procedure for the selection of the recipient of the A.M.A. general practitioner's award was read. In brief, the procedure provides that a nominee should be selected by each county medical society and that from such nominees each State Association would select a nominee for the State and that from the State nominees the A.M.A. would make its final selection. Members of The Council felt that this would require the setting up of orderly procedure, and on motion by Dr. Lincke, seconded by Dr. Swartz, and **carried**, authorized the President to appoint a special committee to work out the procedure for the polling of the county societies and the selection of the Ohio nominee for the A.M.A. award.

BLOOD DONOR PROGRAM

The Executive Secretary pointed out that several county medical societies had requested information as to the policy of the Ohio State Medical Association with respect to the Red Cross blood donor program and he requested The Council to provide him with instructions on this question. Following a general discussion, on motion by Dr. Clodfelter, seconded by Dr. Dixon, and **carried**, The Council endorsed and adopted as a basic principle the report of the Reference Committee adopted by the House of Delegates of the American Medical Association at the Chicago meeting of the A.M.A. in June, 1948, and as published in *The Journal of the A.M.A.*, July 10, 1948. (See page 1139 for text of statement.)

A request from the Ohio State Safety Conference, that the Ohio State Medical Association cooperate in arranging a program for the Conference's section on industrial health during the 1949 Safety Conference, was presented. On motion by Dr. Davis, seconded by Dr. Dixon, and **carried**, the matter was referred to the Committee on Industrial Health and Workmen's Compensation with instructions to work with officials of the Ohio State Safety Conference on such a program.

REGARDING OFFICE ASSISTANTS

A communication from a member, requesting advice on the legal and ethical phases involved in the employment of a clinical psychologist to assist him in his office practice, was discussed. The Executive Secretary was instructed, on motion by Dr. Clodfelter, seconded by Dr. Davis, and **carried**, to advise the member that The Council feels that there would be nothing

training for all grades of nurses in the future, and (3) the economic situation.

EMERGENCY MEASURE

1. Regarding the first it has recommended that retired nurses, including married nurses, be requested to fill in during the emergency. Through the efforts of Dr. W. W. Bauer and with the generous cooperation of the National Broadcasting Company, and the Advertising Council, a great deal of publicity has been given this subject. Many editorials have appeared in *Hygeia* and state and county medical journals stimulating doctors to aid in recruitment of student nurses and urging retired nurses to return to the fold. Personnel trained on the job have been advised and used to supplement nursing services. Trained practical nurses under supervision are being used. Hospital administrators have been requested to use nurses only in nursing duties and to assign other work to auxiliary personnel. It is the feeling of hospital administrators and directors of nursing schools that the situation has begun to show improvement and that it is easier now to obtain nurses in various grades than it was one year ago. The Hospital Career Campaign for the recruitment of student nurses for 1948 gives promise of an increased student nurse enrollment.

TWO CLASSES

2. Under the second heading, which relates to the proposed training of all grades of nurses in the future, your Committee is prepared to make definite and concrete recommendations. We have investigated and studied carefully the question of bedside nursing and the required training for this grade of nurse. We recommend two main classes of nurses: (A) professional nurses, and (B) trained practical nurses.

(A) Professional Nurse.—This group is to be subdivided into (a) nurse educators and (b) clinical nurses.

(a) Nurse educators are to be those with collegiate training and others who have shown an aptitude for teaching, administration and supervisory positions. These are to fill the positions of directors of nursing schools, teachers, department and clinical supervisors, public health nurses, etc. The training for these nurses should be collegiate training before entering the nursing field or combined collegiate and nursing training.

(b) The clinical nurse is to be comparable to the present day general duty or private duty nurse. Selected clinical nurses with an aptitude and ability for teaching may well be considered for some of the subordinate teaching positions. We recognize that there are many duties to be assigned to this grade of nurse which could not be filled by the trained practical nurse. We recommend that the course of training for the clinical nurse be reduced to two years.

TRAINED PRACTICAL NURSES

(B) The Trained Practical Nurse.—Your committee has underscored the word trained. Unfortunately it seems to the committee, the term "practical nurse" bears the implication of no training. However, the term has already been written into the statutes of several states and a change of the name would be difficult. At the same time the committee feels that the name is not of major significance, but does feel, however, that it is very important that uniform standards

of training and duties be established across the country. For this group your committee recommends one year of training made up of three months theoretical and nine months practical training. This can be accomplished completely in a hospital, or the three months theoretical training may be taken under a department of education and the nine months training in an acceptable hospital. Your committee feels that this group of trained practical nurses, under proper supervision of professional nurses and medical staff, will be able to do much of the routine bedside nursing now being done by professional nurses, but that the more delicate and intricate duties must be left to the professional nurse. We believe that sufficient bedside nursing care can be obtained economically and efficiently if the professional nursing staff is augmented by trained practical nurses. Provision should be made, and credits allowed, in selected cases, toward training for advancement from the grade of trained practical nurse to the grade of clinical nurse.

ECONOMIC RELIEF

3. The last or economic problem presents certain features which should be corrected. Your committee urges that steps be taken to provide social security and retirement plans for all nurses. This is advised from the business and moral points of view. We also recommend that hospitals adopt a definite personnel policy, for all institutional nurses, with a view toward making salaries, hours, sick leave and vacations comparable to other fields of endeavor for women with equivalent education and training.

The committee recommends that the cost of essential special nursing care, to the patient, be covered by prepayment nursing plans or be tied into prepayment hospital and medical plans, if practicable.

ACTION AT ATLANTIC CITY

The committee feels that the nurses innocently erred in their action in Atlantic City in 1946 when they voted to have their state organizations act as bargaining agents for them. They are members of a noble profession. They do not need bargaining agents. The term bargaining agent carries with it the implication to strike even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere, any time. They are dealing with that most priceless possession—life itself. It is hoped that the nurses will correct this in the near future.

A permanent Conference Committee made up of representatives of the American Nurses Association and other nurses' organizations, the American Hospital Association and the American Medical Association has been formed. The duties of this committee will be to study the problems common to all. Nursing problems are the most urgent and important at present. This committee might well be used to adjust any differences that any of the groups might have.

The committee wishes to thank Dr. E. L. Bortz, the President of the American Medical Association; Dr. Elmer Henderson and the Board of Trustees; Dr. Morris Fishbein, the Editor of *The Journal*, and the representatives of the American Hospital Association for their cooperation and aid in this study. The representatives of the various nurses' organizations have been very helpful to the committee. They are anx-

ous to have this whole nursing problem solved and have cooperated fully. The committee expresses its gratitude for their aid.

SUMMARY

And so we end, at least for the present, the study of the nursing problem and summarize it as follows:

1. It is estimated that about 400,000 nurses will be required to care for the American people in 1949. The committee feels that this can be accomplished.

2. Labor Department statistics indicate that about 550,000 nurses will be needed in 1960. To accomplish this about 50,000 nurses must be graduated each year between 1951 and 1960. This can be accomplished by the generous cooperation of all concerned.

3. The committee has proposed measures for the relief of the present situation and feels that much has been accomplished.

4. The committee recommends that changes be made in the present method of training nurses; that in the future nurses be made up of two main groups—the professional nurse and the trained practical nurse. The requirements, duties, and courses of training of both main groups have been outlined.

5. The economic situation has been reviewed and methods of correction suggested.

6. A permanent Conference Committee has been formed, made up of representatives of the American Nurses Association, the American Hospital Association and the American Medical Association.

7. The committee believes that this permanent Conference Committee will be the organization to implement your committee's recommendations and the recommendations that come from other interested groups.

Respectfully submitted,

Thomas P. Murdock, Chairman,
Warren F. Draper,
Howard K. Gray,
Leland S. McKittrick,
Donald W. Smelzer.

Ohio Deaths and Births Show Sharp Rise in 1947

The number of deaths in Ohio, after declining gradually from 1943 through 1945 and rising slightly in 1946, rose sharply during 1947, according to the Annual Vital Statistics Report released recently by the Ohio Department of Health.

The number of deaths for the five years were: 1943—82,030; 1944—79,868; 1945—77,625; 1946—77,839; and 1947—82,007. The number of deaths from four leading causes during 1947 were: Diseases of the heart, 26,333; cancer, 10,994; cerebral hemorrhage, 8,378; and nephritis, 4,676.

The numbers of births reached the phenomenal high of 197,296, or a rate of 25.4 per 1,000 population. Other comparative rates were: 1910—21.1; 1920—21.4; 1930—17.6; and 1940—16.6.

Second District Officers

Officers of the Second Councilor District of the Ohio State Medical Association elected at the annual meeting on September 29 in Springfield are: Dr. Forrest E. Lowry, Urbana, president; Dr. Merrill D. Prugh, Dayton, vice-president; Dr. George A. Woodhouse, Pleasant Hill, secretary; and Dr. William H. Hanning, Dayton, treasurer.

Dr. A. A. Brindley, Toledo, President of the Ohio State Medical Association, was a guest at the meeting. He also addressed a luncheon meeting of the district Woman's Auxiliary at Hotel Shawnee on the subject, "A New Medical Co-operative, the Woman's Auxiliary."

More than 120 persons were present for the district meeting.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since September 1, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ATHENS COUNTY

Eleanora Schmidt, Athens

CLARK COUNTY

William H. Crays, Springfield

R. Hugh Mabry, Springfield

R. P. McCulloch, Springfield

CUYAHOGA COUNTY

John F. Brennan, Cleveland

Everett P. Coppedge, Jr., Cleveland

Jack B. Garlin, Bedford

George G. Goler, Cleveland

Robert C. Heskett, Cleveland

LeRoy J. Hyman, Cleveland

Herman F. Inderlied, Cleveland

Harry C. Konys, Cleveland

Samuel H. Lerner, Cleveland

James E. O'Hare, Cleveland

Ralph J. Pelegrin, Cleveland

Harold B. Riser, Rocky River

Russell P. Rizzo, Cleveland

Richard C. Roesemann, Cleveland

Walter S. Sellars, Cleveland

John Joseph Smith, Cleveland

Sewell K. Starcke, Cleveland

Manly Utterback, Cleveland

Dean C. Varney, Cleveland

Charles A. White, Cleveland

HAMILTON COUNTY

Robert G. Armstrong, Cincinnati

Harry J. Bingham, Cincinnati

Gustav Eckstein, Cincinnati

Forman Friend, Cincinnati

Sylvan A. Golder, Cincinnati

Chapin Hawley, Cincinnati

C. Rowell Hoffmann, Cincinnati

Curwood R. Hunter, Cincinnati

Paul N. Jolly, Cincinnati

Richard F. Kelly, Cincinnati

William L. McGowan, Cincinnati

Carl F. Schilling, Cincinnati

LORAIN COUNTY

Theodore E. Finegan, Elyria

PORTAGE COUNTY

Edward P. Reese, Windham

ROSS COUNTY

R. P. Giesler, Chillicothe

Robert E. Swank, Chillicothe

SENECA COUNTY

Henry L. Abbott, Tiffin

SUMMIT COUNTY

Glenn V. Hough, Akron

Norman E. Wentsler, Jr., Akron

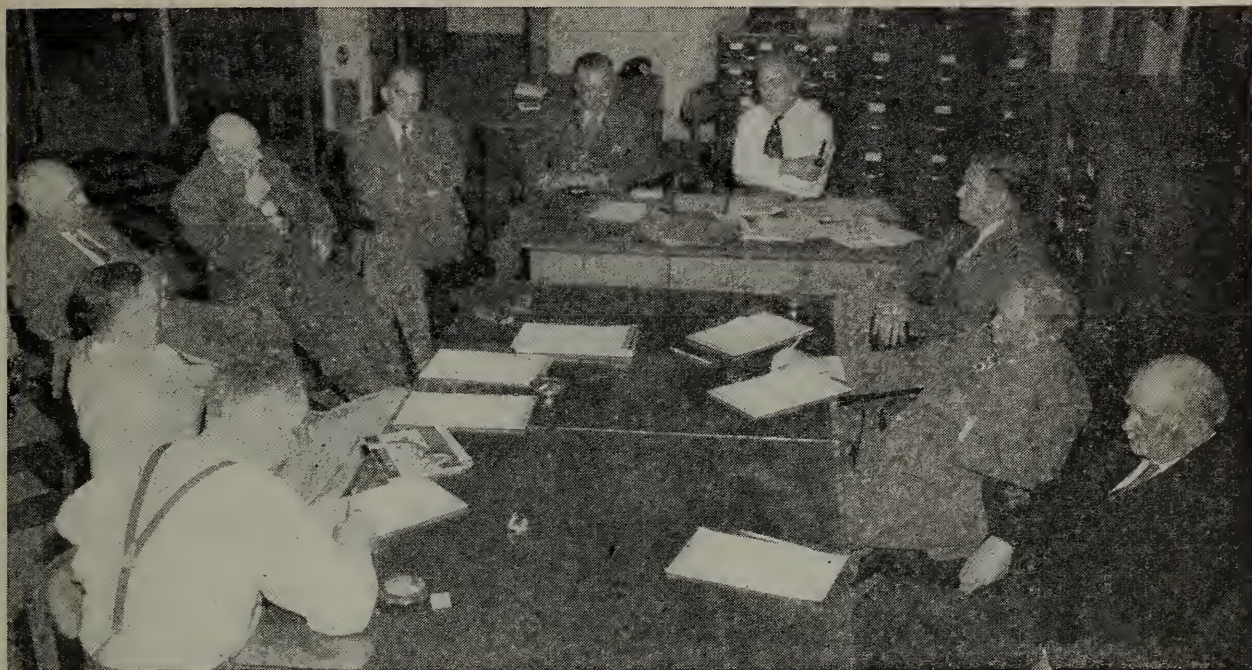
James M. Whitworth, Cuyahoga Falls

Aubrey S. Willacy, Akron

TUSCARAWAS COUNTY

Thomas F. McCough, New Philadelphia

Tenth District Legislative Committeemen Deliberate



The above scene is typical of recent legislative conferences held in each Councilor District leading up to the November 2 general election. Such conferences were attended by county society presidents, secretaries and legislative committeemen, district councilors and either Mr. Nelson or Mr. Saville of the Headquarters Office. The merits and qualifications of candidates for public office and methods of disseminating information to Association members were discussed. The above meeting is that of committeemen of the Tenth Councilor District and was held in the Association's Headquarters Office in Columbus. Clockwise around the table are: Drs. H. P. Worstell, Columbus; C. C. Sherburne, Columbus; Fred C. Calloway, Marysville; F. M. Hartsook, Cardington; Raymond S. Lord, Fredericktown; H. M. Clodfelter, Columbus; Mr. George H. Saville, public relations director for the Association; Drs. A. M. Johnston, Marysville; John M. Thomas, Columbus; and George W. Heffner, Circleville.

O.S.M.J. Staff Photo

unethical in the employment of an office assistant of this kind and that there would be nothing illegal, providing of course such employee would work directly under the supervision of the physician and the physician would assume all responsibility for his acts—a principle applying to all classes of medical assistants, technicians, etc.

There was a discussion of a communication received from a member with respect to fees paid anesthetists under the Ohio Crippled Children's program. The Executive Secretary reported that he had been informed that the present fee schedule used by that division is now being revised. On motion by Dr. Dixon, seconded by Dr. Clodfelter, and carried, this question was referred to the Committee on Public Relations with instructions to confer with the officials of that division on this matter.

DIABETES PROGRAM ENDORSED

A request from the American Diabetes Association, asking the Association to cooperate in an educational program being conducted by that organization, was read and discussed. On motion by Dr. Clodfelter, seconded by Dr. Dixon, and carried, the educational program of the American Diabetes Association was approved in principle and the Executive Secretary requested to suggest to county medical societies that they cooperate with this national organization and its

regional or local units on programs designed to educate the public and the medical profession on the subject of diabetes.

A letter from the National Society for Medical Research, outlining its activities in opposition to antivivisection programs was discussed. On motion by Dr. Lincke, seconded by Dr. Messenger, and carried, a contribution in the amount of \$100 from the State Association to this organization was authorized.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

County Society Officers To Meet in St. Louis

The Fourth National Conference of County Medical Society Officers will be held in St. Louis on Tuesday, November 30, beginning at 7 p. m., in connection with the Interim Session of the American Medical Association. The hotel at which the meeting is to be held will be announced later.

Two panel discussions are scheduled on the following subjects: "Relation of the Doctor to National Preparedness," and "The Public, the Doctor and 'Socialized Medicine.'"

FIRST CALL FOR ENTRIES IN

Scientific Exhibit

1949 Annual Meeting, Ohio State Medical Association

THOSE who attended this year's Annual Meeting in Cincinnati will agree, no doubt, that the Scientific Exhibit was one of the exceptional features of the meeting.

The Committee on Scientific Exhibits for the 1949 meeting, April 19-22, Columbus, is hopeful that the Scientific Exhibit at the 1949 meeting will be even bigger and better than the one in Cincinnati.

This is a general invitation to the members of the Ohio State Medical Association to participate in the Scientific Exhibit. On the opposite page will be found an application blank. If you have an exhibit, fill out the blank and mail it to C. J. DeLor, M. D., University Hospital, Tenth and Neil, Columbus, chairman of the committee. If you know of some colleague who has an interesting exhibit (or should have), suggest to him that he submit an application blank. Fill out the blank completely. Applications will be reviewed by the committee. Details for setting up exhibits will be outlined to those whose entries are accepted.

The 1949 Scientific Exhibit will be held in the Grand Ballroom of the Deshler-Wallick Hotel. The firm which handles exhibits for the American Medical Association—Advertising Displays and Decorations, Cleveland—will supply the equipment and supervise the erection of the exhibit. Equipment and facilities similar to that used at A. M. A. meetings will be used. The accompanying picture shows the type of booth which will be provided.



Type of Booth To Be Used for Scientific Exhibits.

Booths will be of uniform color and design; solidly constructed of wood and wallboard; skirted with velour. There will be a shelf. The upper area will be covered with taut blue crash fabric for bulletin board background and to permit the tacking or taping of charts and specimens without fear of damaging the exhibits. Fluorescent lights are a part of the background.

COMMITTEE ON SCIENTIFIC EXHIBITS

C. J. DeLor M. D., Columbus, Chairman,
William F. Ashe, M. D., Cincinnati,
Paul Hohly M. D., Toledo,
D. K. Spitler, M. D., Cleveland,
Horace B. Davidson, M. D., Columbus,
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APPLICATION

For Space in the Scientific Exhibit

1949 Annual Meeting • Ohio State Medical Association

DESHLER-WALLICK HOTEL

COLUMBUS, OHIO

APRIL 19-22, 1949

Fill Out and Mail to:

C. J. DE LOR, M. D., *Chairman*
Committee on Scientific Exhibits
University Hospital, Tenth and Neil
Columbus, Ohio

1. Title of Exhibit:_____
2. Description or nature of exhibit: (attach 200-word description to this blank.)
3. Will radiologic viewing boxes be needed? If so, state number and size:
Number of boxes needed_____ Size required _____
(Please indicate if you plan to furnish own view box.)
4. Will you require shelf space? If so, how much?_____
5. How much floor space will you require?_____
6. How much back wall space will you require?_____
7. How much side wall space will you require?_____
8. Other material or equipment required:_____
9. Name of exhibitor:_____
- _____ (Street) _____ (City)
10. Name of institution cooperating in exhibit (if desired):_____
- _____
- _____

Costs of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

ALL IS CONFUSION ON USE OF MEDICAL MANPOWER

How medical personnel will be utilized in the present re-armament program and in plans which would become effective in event of war is still the \$64 question.

The first snag arises from the difference of opinion as to how many additional medical officers are needed by the armed services. The armed services contend their needs cannot be met through voluntary enlistments. The opposite view is taken by those who believe that there are a sufficient number of medical officers on duty, or in sight, providing the armed services will revamp their tables of organization and institute plans for more efficient use of medical personnel.

No less than seven or eight Federal commissions, committees or boards have been set up with overlapping responsibilities, among them that of determining how medical and other scientific manpower shall be utilized. They have been unable to agree, adding to the confusion.

Until these situations are ironed out there is little in the way of accurate information which can be passed on to the medical profession. Whether some single uniform policy will be developed prior to the next session of the Congress is anybody's guess. The question is too serious to be decided by hasty action. On the other hand, a solution is being stymied by the mumble-jumble procedure which has been established to get the facts and recommend the policies.

U. M. W. MEDICAL PLAN GAINS MOMENTUM

Step up in the operation of the United Mine Workers medical and hospitalization fund may be anticipated as a result of actions taken at the recent U. M. W. meeting in Cincinnati. Medical officers for various districts are being selected. These men will work out agreements with local physicians and hospitals for services to be paid for out of the fund which comes from royalties on each ton of coal mined. According to reports, John L. Lewis has indicated that existing medical personnel and hospital facilities will be utilized and that the U. M. W. will not engage in a facilities building program—at least not now.

Here is an experiment of vast scope. Only experience will show whether it should or should

not be an accepted pattern for other groups of organized workers. Lewis apparently is committed to a program which will not be run by the Federal government, which is contrary to the views of leaders of some of the other larger labor organizations. If sound medical policies are adopted under the guidance of qualified representatives of the medical profession, the plan may work to the benefit of all concerned. Time and the degree of wisdom demonstrated by U. M. W. officials and the fund executives will tell. It will be necessary for the medical profession to keep in close touch with the plan as it develops as it has so far with the preliminary planning.

DOCTORS CAN MAKE OR BREAK THE VOLUNTARY PLANS

Our attention has been called to "Blue Cross Briefs," an attractive information bulletin prepared by Hospital Care Corporation, Cincinnati, the Blue Cross Hospitalization Plan of southwestern Ohio. This is being sent to those who render service to Blue Cross members, including physicians of that area.

Following are a few excerpts from October "Blue Cross Briefs" which reveal the important role the medical profession plays in Blue Cross activities and how necessary it is for all physicians to keep in mind the basic principles underlying the voluntary prepaid hospitalization plans. The same may be said of the physician's obligation to the voluntary prepaid medical care plans, such as Ohio Medical Indemnity sponsored by the Ohio State Medical Association.

To quote from "Blue Cross Briefs":

"The Blue Cross Plan has become a national movement. More than 30 million Americans—over one-fifth of the total population—are now members. In our own 14-county area of southwestern Ohio, half of the population—750,000 persons—have Blue Cross membership . . . all enrolled in less than nine years.

"The medical profession can share with us pride in this accomplishment. Here in southwestern Ohio we have had the finest cooperation and assistance from the profession as a whole and from doctors individually. Without this assistance, we could not have enrolled so many members in so short a time.

"In fact, the success of Blue Cross has been and always will be in the hands of the medical profession. The doctor determines when hospital care is necessary, the type and amount

of service and medications to be provided and thereby fixes the liability of Blue Cross to the hospital.

"The doctor, then, plays a major role in Blue Cross economics.

"The medical profession can, therefore, make or break Blue Cross. We of Blue Cross are grateful to the doctors of this area for their understanding cooperation in making this non-profit community service a success.

"Our goals are the same—better health for the people of our community without compulsion or regimentation."

"HOW ARE WE GOING TO LICK CANCER?"

The letter which follows was published in a recent issue of *Philadelphia Medicine*. It was signed "A heartbroken and disillusioned daughter," who, judging from the text of the letter, is a person of considerable intelligence. It seems unnecessary to offer any comment. The lesson which each physician can learn from the experiences related is quite obvious.

With regard to the fund raising campaign which is being conducted to conquer cancer, may I offer a few facts, the way I see them?

Twenty months ago we buried my Mother, a victim of cancer. She passed away in July, 1946. In March of 1946, following an operation to correct the disease, the family was informed that we could expect to have our Mother no longer than 6 months from that date. She, of course, was not told. When we questioned the attending physicians, they informed us that had she had medical attention or gone for an examination 5 or 6 years previously, she most certainly could have been saved. What they did not know, however, was that for over a period of six months she had gone to her family physician complaining of not feeling well, and requesting him to give her a complete check-up. On each occasion, he looked her over casually and remarked that she was perfectly all right and that there was no reason to undergo a thorough examination, since he felt certain that there was nothing the matter with her. After continuing to feel more tired and unwell, she again went to him and practically begged him to take X-rays. This he refused to do, saying it would just be a waste of money, since he was convinced she was physically all right. *This series of requests by my mother occurred exactly 5 years before her death.*

Shortly after her death, my Father went to another physician for a check-up. He was given a routine examination and told the only thing that could be found wrong was a mild case of hemorrhoids which could not be considered serious. *Tomorrow at 2 p. m. we bury him, a victim of cancer of the rectum.*

Recently, a physician gave up his practice in "X-burg" after a period of several years. He was supposed to be considered one of our outstanding physicians during his years of practice here. Several months after he started his practice here I was not feeling well, and not having had a check-up for quite a few years, thought it advisable to have one. I had been

having him tend my children, and so considered him the logical man to go to. The woman who went into his private office immediately preceding me was in for quite a length of time, longer than usual. When I went in, he remarked to me that it would be a great help to doctors if people who only thought themselves ill would not take up a doctor's time with imaginary ailments, and let more time for those who were really ill. Then he informed me that she had requested a thorough examination when he knew that to look at her there couldn't be anything wrong with her physically. Having come to him for the same purpose, I was naturally too embarrassed to ask for the same thing, and, therefore, merely asked for a tonic and left the office. Three months later I was seriously ill as a result of not having medical attention in time.

I realize that doctors are only human, and that they are overtaxed, and I realize too, that all doctors are not alike, but after experiences such as these, one gets quite provoked at having radio announcers and newspapers announce daily to see your doctor while you are still well and not wait until cancer really catches up with you before doing something about having an examination. As long as we have family physicians taking the attitude that they do not have the time or inclination to be bothered with people who are not really ill, *how are we going to lick cancer?*

I do not think I can be considered a "crank" or fanatic, but I do think that one of our first considerations, if cancer is going to be conquered at all, is to start education of a goodly percentage of our physicians.

A heartbroken and disillusioned daughter,

Mrs. P. F.

VANISHING RIGHTS OF THE STATE OF OHIO

Recently, the Richmond, Va., *News-Leader* published an editorial entitled "Locking the Stable on States' Rights," commenting on the current row over civil rights.

The following paragraph is taken from that piece: "In 1926 James M. Beck published his 'Vanishing Rights of the States' and thereby opened a nation-wide argument. The contention of this newspaper then was that the rights of the states were 'vanishing' because in many matters of rightful public demand, the states failed to act and thereby shifted the demand from state capitals to Washington. States were losing their rights because of their neglect and not because of Federal usurpation."

Truer words were never written. Take Ohio, for example, and the way it has treated its own public health set-up. Well-to-do Ohio has been short-changing its state health department. In order to give even minimal services and retain competent personnel, it has had to look to Washington for a substantial portion of its operating funds. Many local health departments have had to stick out a hand to Washington repeatedly simply because the community has failed to raise sufficient money to

finance services which the people require and demand.

Sure, Ohio has been losing its rights in this and other fields of public service through its own neglect and don't care attitude. At the same time, there are probably lots of folks in Ohio who would like to lock the stable before more of Ohio's rights vanish. These same people probably would like to see Ohio have a stronger, better public health system. If that's true, then it would be well for them to get busy and let their public officials and legislators know how they feel. Also, they will have to show more indication than in the past that they are willing to foot the bill.

Until this happens, the "vanishing" process will continue but Ohioans will still be footing the bill indirectly, plus the neat cut which Washington takes before it returns part of the take in the form of so-called subsidies or grants-in-aid. Ohioans ought to be smart enough to see that the present set-up is neither good government nor good business.

DON'T MAKE US LAUGH, OSCAR; WE'VE GOT A CRACKED LIP

Recently Federal Security Administrator Oscar Ewing was interviewed on the radio regarding his 10-year health program, including a proposal for compulsory sickness insurance. When asked why the physicians are fighting compulsory sickness insurance, Mr. Ewing is reported to have replied:

"I don't know. I think they've got a completely mistaken view about it. They bring up a lot of fantastic arguments that don't even have any application. They talk about there being politics in it. There's no place for politics."

Having had some experience with Mr. Ewing and his department—and his chief, Mr. Truman—this causes us to burst forth in a big chuckle.

No, Mr. Ewing, the medical profession hasn't any mistaken ideas about the matter. Don't forget that the medical profession has had a few experiences with Washington bureaus and the White House from 1933 to the present. It is neither dumb nor naive.

SPECIAL MEETINGS FOR INTERNS AND RESIDENTS

Here's a suggestion to Program Committees of County Medical Societies in communities having hospitals with interns and residents.

The Jackson County Medical Society at Kansas City, Missouri, had a dinner with interns and residents as guests. The dinner was followed by a panel discussion during which the interns and residents could ask questions and take part

in the free-for-all discussion. The subject was on "Rural Medical Practice."

The idea is a good one. Meetings of this kind could be held on any number of subjects directly related to active practice. Get your society to arrange some meetings of this kind. A lot of valuable information and advice gained from years of experience can be passed on to the beginners by carefully selected members of the panels. The neophytes will benefit; so will the oldsters.

WHAT PRICE SOCIAL SECURITY IN 2000?

The Chicago Journal of Commerce in its "Round Table" states that death rates and life expectancy statistics indicate that by 1960 there will be about 14,000,000 persons in the United States 65 years of age or older; that by the end of the century the figure may be 21,500,000. Then it adds the observation that even mere subsistence social security at government expense "would be an intolerable burden for the steadily decreasing number of employable citizens who would have to be taxed to support not only social security but all other government activity."

In other words what price social security, so-called, in 1960 and later?

Something to think about, isn't it?

PROPOSED NEW WELFARE SETUP DISCUSSED

Since the medical profession has a direct interest in many of the activities of the Ohio Department of Public Welfare and in the way they are administered, Ohio physicians will be interested in a discussion of "a new plan for state welfare administration" published in the August 30 *Newsletter* of the Ohio Citizens' Council for Health and Welfare, Columbus.

The leading paragraph states: "A revision of the present plan of administering the public welfare functions of the State of Ohio is under consideration by persons close to the problem. So far no 'official' proposals have been offered but there is a possibility that this may be done before the next meeting of the General Assembly."

After reviewing briefly the present administrative setup, the *Newsletter* presents the following comments regarding the new proposals:

"One of the proposals for changing the foregoing pattern would simply transfer the Mental Hygiene Division to the State Health Department, leaving the other divisions intact under the Welfare Department. Detailed consideration of this plan will not be given in this *Newsletter*. Your staff believes that the separation of institutional management—penal and mental—into two separate departments would be so uneconomical as to warrant rejection of the proposal.

"The other proposal deserves study. It would establish an entirely new Department of Public

Assistance having responsibility for the functions now included in Aid for Aged and Social Administration. It would leave in the Welfare Department (perhaps renamed the Department of Institutions and Mental Hygiene) the penal program, the mental hygiene functions and the juvenile study and industrial training units.

"The reasons why such a plan is receiving support in certain quarters are usually given as follows:

"1. The present department is too large and involves too many varied functions to receive proper attention by a single director.

"2. The state's responsibility for public assistance and its administration of institutions are distinct and separate functions and should have separate directorships responsible to the Governor.

"3. The public, through its representatives in the General Assembly and otherwise, could give closer scrutiny to welfare expenditures and needs by a separation of the two functions.

"The first reason is given great weight by those familiar with the problem. It is emphasized that few men are able, during the two years of their appointment as director of welfare, to become familiar with the needs of the mental hygiene program, the penal system, the treatment of juvenile delinquents, the various relief measures, child welfare, et al. It is claimed that one or more of these programs usually suffers as a result.

"Reasons given for the desirability of maintaining the present all-inclusive State Department of Public Welfare are usually as follows:

"1. Greater economy and integration of services is possible by combining all welfare tasks in one department under one man responsible to the Governor.

"2. The broad aims of the state's social welfare programs would be hindered by arbitrarily separating them into independent parts.

"3. The addition of another cabinet member reporting to the Governor is wasteful of public funds and would add to the likelihood that 'politics' would influence welfare programs.

"Other states are operating under both the combined-services plan and under a plan of separate departments. Pennsylvania has a Department of Mental Hygiene, a Department of Public Assistance, and a Department of Public Welfare. New York also operates under a plan of separating these functions. New Jersey has long been successful, however, with a single department."

The advantages or disadvantages of the proposals listed will need careful study. Because the welfare department has become so large, ways to improve its management must always be studied. At the same time, the General Assembly will have to be sure of its ground before it makes fundamental changes in the present setup. Physicians who work closely with the department—few physicians do not in these days—should be thinking about the matter. Since many of the department's activities involve medical and health services for many Ohioans, the medical profession must be in on the ground floor when and if proposed changes are considered or enacted.

EXTRA THREE MINUTES WILL PAY DIVIDENDS

Out in Colorado, where they have get-up as well as mountains, they have organized a "Three Minute Club." To belong, a physician has to agree to spend an extra three minutes, or more, with each patient after completing his professional services. The extra time can be used to get better acquainted, to offer words of reassurance, especially to the emotionally upset patient, to discuss medical, social, and economic questions, or whatnot. Just a little chit-chat to let the folks know that doctors are human.

You can't beat this as a public relations project. Try it. You don't have to organize a club unless you want to organize your own one-man exclusive club. Anyway try it.

WHOSE FAULT IS IT WHEN COLLECTIONS FALL OFF?

Why do some physicians have difficulty in collecting from their patients?

Whose fault is it?

A study recently completed by the Alameda County Medical Society, San Francisco, based on analysis of some 1500 delinquent accounts which had been referred to the society for collection, shows that the physician is too often the offender.

For example, 30 per cent of the accounts were delinquent because of no billing on the part of the doctor, failure to itemize statements, no collection follow up, insufficient information on patients.

Another 21 per cent of the accounts were delinquent because the physician failed to work out a financial arrangement with the patient or to advise him of extra costs, such as laboratory fees, charges for medicines, etc.

About 19 per cent of the uncollected accounts resulted from unemployment, unusual expenses, etc.—what might be termed adjustable economic difficulties.

Real "dead-beats" made up 11 per cent and slow-pay patients 10 per cent. Three per cent indicated they were dissatisfied with treatment; 3 per cent indicated someone else owed the bill; 2 per cent thought the fee excessive; and 2 per cent gave some other cause.

Obviously, some of the reasons given for failure to pay the physician's bill were strictly matters of personal opinion, dissatisfaction, and the like. Nevertheless, the bulk of the trouble would appear to be sloppy office routine or failure on the part of the physician to discuss the important matter of charges with the patient, make adjustments when indicated, explain the items on the bill, and do other things which combine to win the confidence of the patient and make him feel as if he is a person—not just a case and number.

It Isn't Too Early

To Make Hotel Reservations

for the

1949 ANNUAL MEETING

Ohio State Medical Association

Columbus, Ohio — April 19-20-21-22



NAME AND LOCATION	SINGLE	DOUBLE	DOUBLE TWIN BED
NEIL HOUSE, 35 So. High St. (Headquarters Hotel)	\$4.00-7.00	\$6.00-11.00	\$8.00-11.00
DESHLER-WALLICK, Broad and High Sts.	\$3.50-9.00	\$6.00-14.00	\$6.00-14.00
FT. HAYES, 31 W. Spring St.	\$4.50-6.00	\$6.50- 8.50	\$7.00- 9.00
CHITTENDEN, High and Spring Sts.	\$2.75-4.00	\$5.00- 6.00	\$7.00 and up
SENECA, 361 E. Broad St.	\$3.50 and up	\$5.00 and up	\$7.00 and up
SOUTHERN, High and Main Sts.	\$2.50 and up	\$4.00 and up	\$5.00 and up
VIRGINIA, Third and Gay Sts.	\$3.00-4.00	\$4.50- 5.50	\$6.00- 7.00
BROAD-LINCOLN, 631 E. Broad St.	\$3.00 and up	\$5.00 and up	\$7.00 and up

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Mail the coupon to hotel selected

Manager.....Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, April 19, 20, 21, 22, 1949, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price:.....
☐ Twin Bed Room with bath ☐ Suite

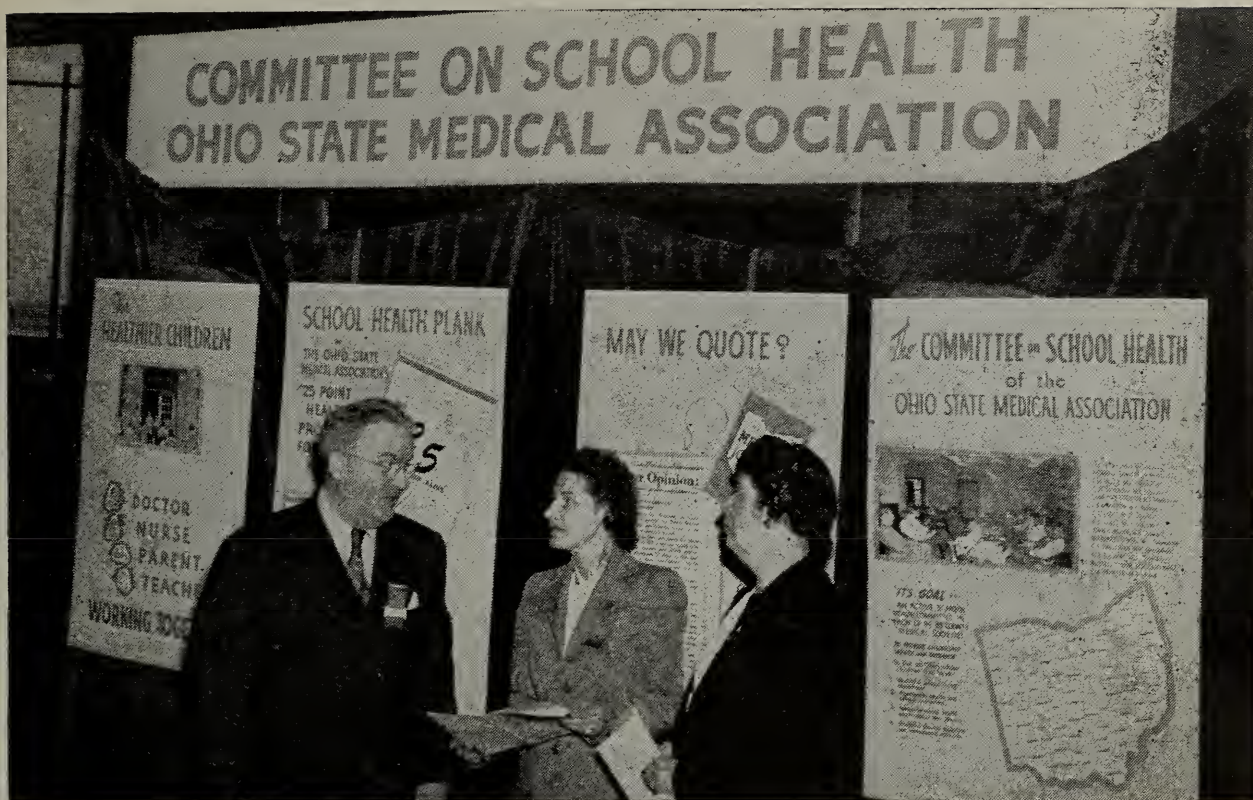
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PLEASE VERIFY MY RESERVATION.

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Association's Exhibit at Congress of Parents and Teachers



Mrs. A. G. Thomas (center), director of exhibits for the Congress, and Mrs. Vern Davis, director of the organization's department of health, discuss with Mr. George H. Saville, director of public relations for the Ohio State Medical Association, one of the many pamphlets on health distributed at the booth.

Association Works With P. T. A. On School Health

The story of the Ohio State Medical Association's school health program was told at the Forty-third Annual Convention of the Ohio Congress of Parents and Teachers in Cleveland, September 20-22, through the above-pictured exhibit.

The exhibit dramatizing the Association's program as laid out by the Committee on School Health, headed by Dr. Carl A. Wilzbach of Cincinnati, was in a strategic setting since one of the principal objectives emphasized at the convention was the improvement of health among school children.

The Congress approved a resolution advocating appropriation of more financial aid for the promotion of health through the schools. The Congress, in further promotion of this principle, announced a series of health conferences to be conducted by the organization's district directors, during which the local responsibility for health programs was to be emphasized.

The Ohio Congress represents more than 346,000 members. The Association was represented at the Congress by Mr. George H. Saville, director of public relations, and Mr. Hart F. Page, assistant director of public relations.

Association's Brucellosis Program Continued Throughout State

Several activities during October and late September continued to promote throughout the State, the anti-brucellosis program of the Ohio State Medical Association's Committee on Rural Health, headed by Dr. Carl S. Mundy, Toledo.

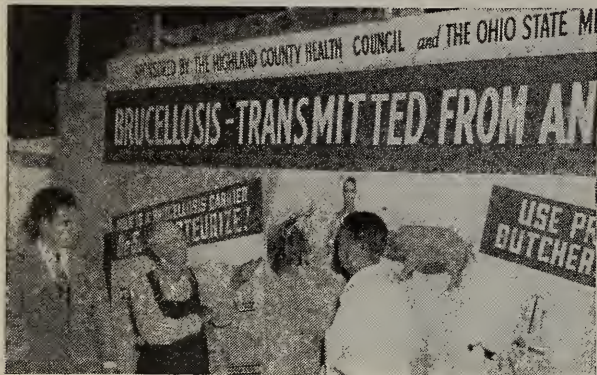
More than 85,000 copies of the brucellosis pamphlet, "Mr. Farmer, Protect Your Family From the Advancing Menace," have been distributed, and calls for additional pamphlets are still being received.

Borden's Dairy & Ice Cream Co. requested and received 4,300 copies to be distributed with their milk checks. The Cleveland office of Telling Belle Vernon Co. received 3,200 for the same purpose.

The elaborate brucellosis exhibit displayed at the State Fair in Columbus also was staged at three county fairs: The Jackson Apple Festival, September 22-25; The Highland County Fair, September 21-24; The Pomeroy Festival in Meigs County the week of October 11; and the Circleville Pumpkin Show, October 20-23. At the Jackson festival the exhibit was co-sponsored by the Jackson County Medical Society and at the Circleville fair by the Womans' Auxiliary to the Pickaway County Medical Society.

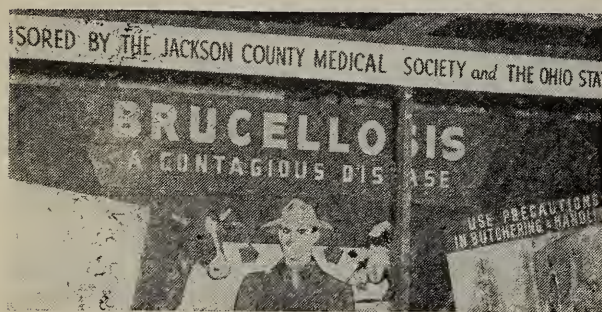
The Committee on Rural Health was rep-

resented on WOSU's "Farm and Home Hour," at noon on October 12 by its secretary, Mr. Hart F. Page. Mr. Page and Mr. Sewall Milliken, extension specialist in rural health, Ohio State University, were interviewed on the subject "Progress in Rural Health" by Dick Cech, farm radio editor of the radio station.



Examining the Association's panels at the Highland County Fair are: H. F. Reed, Hillsboro; J. E. Ruppel, Greenfield; and D. R. Hottle, Hillsboro, all members of the Highland County Health Council, co-sponsors of the exhibit.

Items discussed included: (1) The brucellosis campaign currently sponsored by the Association and the Ohio State Veterinary Medical Association with assistance of the extension service and the Ohio Department of Health; (2) the 4-H Club health contest; (3) the place-



The Jackson County Medical Society co-sponsored the Association's brucellosis exhibit at the Jackson Apple Festival.

ment service of the Ohio State Medical Association and its role in obtaining physicians for rural areas; (4) what small communities can do to attract physicians; and (5) future projects in rural education to be taken up by the Ohio State Medical Association with the cooperation of various related organizations.

Thomas J. LeBlanc, D.S., professor of preventive medicine at the University of Cincinnati College of Medicine, died September 9, at the age of 54. He received his doctor of science degree from Johns Hopkins University.

Ohio State Schedules Medical Study Course Dec. 6-11

In association with the Diamond Jubilee celebration of Ohio State University, the College of Medicine will conduct its second annual session Medical Study Course for six days, Monday, December 6, through Saturday, December 11.

The program includes a variety of courses to be conducted under direction of respective

Ohio State Medical College Alumni Day, Dec. 11

Alumni and friends of the Ohio State University College of Medicine are invited to attend the 11th Post-Collegiate Assembly on Saturday, December 11, to be given in conjunction with the Second Annual Study Course. Those attending only this one day session will pay an Alumni Day fee of \$5.

Included on the program are medical study courses beginning at 9 a. m.; an Alumni luncheon, and an afternoon session highlighted by presentation of the Alumni Achievement Award.

departments of the College. The courses will begin at 9 a. m. each morning, with afternoon sessions, and on some days late afternoon or evening special lectures.

The faculty of instruction will consist of picked members of the College faculty, headed by Dean Charles A. Doan, and seven visiting lecturers.

The visiting faculty will include: Dr. Claude S. Beck, professor of neurological surgery, Western Reserve University; Dr. Louis G. Herrmann, associate professor of surgery, University of Cincinnati; Dr. Robery Lyon, associate professor of pediatrics, University of Cincinnati; Dr. William Middleton, professor of medicine and dean of the Medical School, University of Wisconsin; Dr. Patrick L. Mollison, British Post-Graduate Hospital, Medical Research Council, London, England; Dr. Dallas B. Phemister, professor emeritus, department of surgery, University of Chicago, and Dr. J. Robert Willson, chairman of the department of obstetrics and gynecology, Temple University School of Medicine, Philadelphia.

Registration will be limited by the physical facilities only. The fee for the course will be \$30.

Detailed information may be obtained by communicating with Dr. Robert M. Zollinger, chairman of the Committee for Postgraduate Study, in care of the College of Medicine.

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RESEARCH IN THE SERVICE OF MEDICINE

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Do You Know? . . .

The Metropolitan Health Council, a division of the Council of Social Agencies of Columbus and Franklin County, has proposed that the five health departments in the county be merged into one county health department. Dr. Thomas E. Rardin, Columbus, is president of the Council.

* * *

The Woman's Auxiliary to the Ohio State Medical Association now has 45 local units and approximately 3,400 members.

* * *

The Bureau of Medical Economic Research of the American Medical Association estimates that there were 199,755 physicians in the United States as of June 1, 1948. This is 17 per cent greater than the number listed in the 1940 A. M. A. directory. The population of the United States has increased 12 per cent since 1940.

* * *

Tripler General Hospital, the Army's 14-story, 1,500-bed hospital in Hawaii, occupies 365 acres of land and cost \$33,000,000. The hospital is of earthquake-resistant construction.

* * *

Dr. Donald W. Bortz, Cleveland, was one of the guest speakers at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania, at Philadelphia, Oct. 3-7. He participated in a symposium on the treatment of anemia.

* * *

The American Medical Association is building a five-story addition to its headquarters in Chicago. It will provide 35,000 square feet, or approximately 25 per cent more floor space and will cost \$500,000. According to General George F. Lull, secretary of the A.M.A., "the expansion is necessary to meet the rapid social and economic changes in the problems of medical care for the nation, which have multiplied in the last five years."

* * *

"What Every Doctor's Wife Should Know About Public Relations," was the topic discussed by George H. Saville, Director of Public Relations, Ohio State Medical Association at meetings of the Woman's Auxiliary to the Summit County Medical Society, at Akron, Oct. 5, and the Woman's Auxiliary to the Montgomery County Medical Society, at Dayton, Oct. 12.

* * *

Establishment of the National Institute of Dental Research under authority of an Act of Congress has been announced by Federal Security Administrator Ewing.

The sole representative of the medical profession in the National Hall of Fame in Washington, D. C., is Major Walter Reed of the Army Medical Corps. Of the 77 persons so honored, Major Reed is the fifth from the Army. Others are Generals Washington, Grant, Lee, and Sherman.

* * *

Guest speakers at the Fall Clinical Conference of the Kansas City Southwest Clinical Society, Oct. 4-7, at Kansas City included Dr. Howard Karsner, Cleveland, who spoke on "Acute Inflammations of Arteries," and Dr. George Crile, Jr., Cleveland, who discussed "Treatment of Peritonitis and Intra-Abdominal Abscess."

* * *

Dr. Shelby G. Gamble, Columbus, has been appointed head of the Department of Physical Medicine at the Cleveland Clinic. Dr. Gamble was assistant professor of medicine at the Ohio State University College of Medicine and director of the Departments of Physical Medicine at University and Children's Hospitals, Columbus.

* * *

The diabetes detection drive of the American Diabetes Association, Inc., will be initiated by Diabetes Week, Dec. 6-12.

* * *

Reprints of the article entitled "Breath of Life," depicting the over-all problem of asphyxia, which appeared in the August, 1948, issue of the *Woman's Home Companion*, may be obtained, without charge, from the Society for the Prevention of Asphyxial Death, Inc., 205 East 78th St., New York City.

* * *

Dr. Paul O. Peterson, chief, Bureau of Direct Service, Ohio Department of Health, spoke on "Promoting Better Health Services," at the Fall Workers' Conference of the Ohio Tuberculosis and Health Association, Oct. 8, at Columbus.

* * *

Dr. William H. Bunn, Youngstown, was one of the guest speakers at the recent postgraduate assembly of the Chicago Medical Society. He spoke on "The Treatment of Coronary Heart Disease," and "The Treatment of Congestive Heart Failure."

* * *

At the recent annual meeting of the Ohio Society of Anesthesiologists in Toledo, the following officers were elected: Dr. Kenneth C. McCarthy, Toledo, president; Dr. George Collins, Columbus, vice-president; and Dr. B. B. Sankey, Cleveland, secretary-treasurer.



medical experience points to multivitamin supplementation, accompanying balanced diet, as the best guaranty of adequate vitamin intake. When vitamins are thus directly administered, nutrients essential to the patient's progress are provided with *certainty, precision and economy*. For prophylaxis and for therapy, Upjohn prescription vitamins are available in a range of potencies and formulas filling the practical requirements of physicians and surgeons.



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In Memoriam . . .

Harry Sherwood Allen, M. D., Ironton, Miami Medical College, Cincinnati, 1895; aged 75; died September 11; member of the Ohio State Medical Association, and a Fellow of the American Medical Association; president of the Lawrence County Medical Society, 1928-29 and 1942-45, and its secretary in 1924. Dr. Allen practiced his profession in Ironton since 1916 and for the past 17 years was city health commissioner. He was a member of the Methodist Church, the Elks Lodge and took an active part in business and civic life of the community. Surviving are his widow, a son, and a daughter.

Ward Ariel Anderson, M.D., Portland, Ore.; Ohio Medical University, Columbus, 1906; aged 72; died August 24. Dr. Anderson practiced in Harrison County before moving to Oregon in 1911. Surviving are his widow, three sons, a daughter, and a brother.

Don Bertus Biggs, M. D., Findlay; Starling Medical College, Columbus, 1902; aged 75; died September 24; member of the Ohio State Medical Association and a Fellow of the American Medical Association; chairman of the legislative committee, Hancock County Medical Society, 1927 and 1943-45. Dr. Biggs practiced medicine in Hancock County since completion of his medical education and at one time was county coroner. He held memberships in the Findlay Country Club, Phi Delta Theta, the Elks Lodge, Knights of Pythias, Modern Woodmen of America and several Masonic Orders. Surviving are his widow and three sisters.

Munson Russell Bixel, M. D., Bluffton; Eclectic Medical College, Cincinnati, 1925; aged 52; died October 4; former member of the Ohio State Medical Association and the American Medical Association through 1947. Dr. Bixel practiced medicine in his community for the past 21 years, during part of which he was a member of the Allen County Board of Health. He also served on the Bluffton city council. Dr. Bixel was a veteran of World War I and held membership in the American Legion, the Lions Club, the Mennonite Church and was a trustee of Bluffton College. Surviving are his widow, a son, a daughter and two sisters.

Norman E. Brundage, M. D., Delphos; Fort Wayne College of Medicine, 1892; aged 85; died October 8 in Rockford; former member of the Ohio State Medical Association and the American Medical Association through 1933. Dr. Brundage practiced medicine in Delphos for approximately 50 years. He was for a number of

years head of the local board of health and served on the local school board. Surviving is one sister.

Edwin James Cauffield, M. D., Akron; Cleveland University of Medicine and Surgery, 1895; aged 76; died October 8. Dr. Cauffield practiced medicine in Akron for more than 50 years. He was secretary of the Summit County Historical Society and was a member of several Masonic Orders. Surviving are a son, Dr. Edwin W. Cauffield of West Richfield and two daughters.

Kurt Eichwald, M. D., Zanesville; University of Berlin, 1920; aged 56; died August 31; member of the Ohio State Medical Association and the American Medical Association. Dr. Eichwald came to this country in 1938 and moved his practice to Zanesville eight years ago. He was a member of the Beth Abraham Synagogue and was active in civic affairs of the community. Surviving are his widow, a daughter and a son.

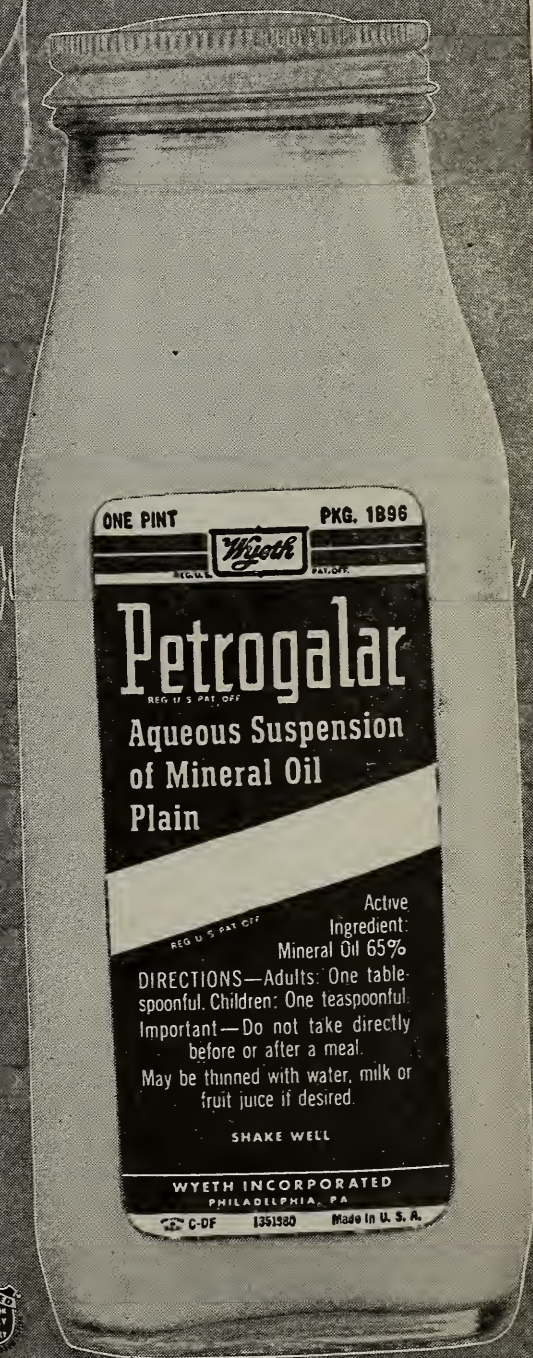
Walter R. Evans, M. D., Jackson; Starling Medical College, Columbus, 1896; aged 75; died September 3. Dr. Evans had practiced his profession in the vicinity for approximately 53 years and from 1910 to 1920 served as Jackson County coroner. He was a member of the Presbyterian Church and the Masonic Lodge. Surviving are a son, Dr. Walter Evans of New Rochelle, N. Y., a sister and a brother.

Frederick Andrew Fischer, M. D., Cincinnati; Eclectic Medical College, Cincinnati, 1917; aged 53; died September 24. Dr. Fischer practiced medicine in Cincinnati from the completion of his medical education until his retirement a few years ago. He was an active member of several Masonic Orders. His mother survives.

William Harris Gitman, M. D., University of Louanne, Faculty of Medicine, Switzerland, 1938; aged 40; died September 3; member of the Ohio State Medical Association and the American Medical Association. A native of Dayton, Dr. Gitman practiced his profession there since completing his education, except for the time he spent with the Army Medical Corps during the war. He was an advocate of sports, having played varsity football. He was a member of the War Veterans Republican Club and was Republican candidate for the office of Montgomery County coroner. Dr. Gitman was a member of the Masonic Lodge and B'nai B'rith. Surviving are his widow, three sons, a daughter, his mother, three brothers and a sister.

Otto C. Griep, M. D., Dayton; University of Louisville School of Medicine, 1893; aged 81;

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TIME



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died September 18; former member of the Ohio State Medical Association and the American Medical Association through 1925. Dr. Griep practiced medicine in Dayton for more than 50 years. He was a member of the Masonic Lodge. Surviving are his widow, two daughters, one brother and three sisters.

John S. M. Hamilton, M. D., Camp Stoneman, Pittsburg, Calif.; McGill University Faculty of Medicine, Montreal, 1926; aged 47; died September 11. A surgeon in the Army, Col. Hamilton formerly was stationed in Columbus. Surviving are his widow, a son, two daughters, his father and three brothers.

Noah Sherman Hilty, M. D., Pandora; Detroit Homeopathic College, 1904; aged 71; died September 5. In addition to his medical practice, Dr. Hilty formerly filled the office as mayor of Pandora, and served as president of the board of education. Surviving are four sons, a daughter and six brothers.

Joel Dubois Holston, M. D., Massillon; Eclectic Medical College, Cincinnati, 1896; aged 80; died September 27; member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947; Diplomate of the American Board of Radiology; member of the Radiological Society of North America, Inc., and the American College of Radiology. Dr. Holston practiced his profession for more than 50 years and was active until his retirement about two years ago. During World War I he served in the Army Medical Corps. He was a former member of the Massillon board of education, was on the vestry of the Episcopal Church and was a member of the Masonic Lodge. Surviving are his widow, two brothers and three sisters.

Rinaldo M. Hughey, M. D., Washington C. H.; Columbus Medical College, 1891; aged 81; died September 1; member of the Ohio State Medical Association and the American Medical Association; president of the Fayette County Medical Society in 1918; delegate to the O. S. M. A. in 1920, 1925, 1926, 1929 and 1930; chairman of the legislative committee of his society 1926-34. In addition to his almost 50 years of practice in Washington C. H., Dr. Hughey served for two terms in the Ohio House of Representatives. He was president of the city board of education for a number of years, was a charter member of the local Rotary Club and its president at one time, and was active in several Masonic Orders. Surviving is his widow.

Victor K. Knapp, M. D., Nevada, O.; Medical College of Ohio, Cincinnati, 1896; aged 78; died September 8. Dr. Knapp practiced throughout his professional career in Wyandot County. He

was a member of the Masonic Lodge. Surviving are his widow and a son.

Thurman Holmes Lautenschlager, M. D., Santa Barbara, Calif.; University of Cincinnati College of Medicine, 1912; aged 60; died September 25; former member of the Ohio State Medical Association and the American Medical Association through 1932. Dr. Lautenschlager's professional activities extended to several sections of the State. He practiced for a number of years in Youngstown and during another period taught medical-legal jurisprudence at the University of Dayton. He served as a director of the industrial committee of the Ohio State Bar Association. During World War I he served with the Army Medical Corps. Organizations of which he was a member included several Masonic Orders. Surviving are his widow, a son, a daughter, his mother, a sister and a brother, Dr. Harry W. Lautenschlager of Dayton.

Lee H. Mann, M. D., Louisville, Ky.; Columbus Medical College, 1883; aged 87; died October 2; former member of the Ohio State Medical Association and the American Medical Association through 1934. Dr. Mann completed more than 50 years of practice, much of it in Columbus, before retiring a number of years ago. Surviving are two daughters.

Elmer Lincoln Mather, M. D., Akron; Starling Medical College, Columbus, 1892; aged 80; died October 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Mather practiced medicine in Akron for approximately 30 years. Late in his career he studied law and passed the state bar examination. He was a member of the Masonic Lodge, the Philosophical Society, the Akron Men's Garden Club and several other professional and fraternal organizations. Surviving are his widow, a son, a daughter, two brothers and a sister.

Harry McAnall Mealy, M. D., Detroit, Mich.; University of Wooster, Medical Department, Cleveland, 1891; aged 78; died September 25; former member of the Ohio State Medical Association and the American Medical Association through 1933. Dr. Mealy formerly practiced in Newton Falls and Palmyra. Surviving is one sister.

Eugene Poland Mitchell, M. D., Defiance; University of Louisville School of Medicine, 1923; aged 54; died September 12; member of the Ohio State Medical Association and the American Medical Association; secretary-treasurer of the Defiance County Medical Society 1936 through 1947. Dr. Mitchell practiced medicine in Defiance since 1932 and for eight years was city health commissioner. He was a member of the Presbyterian Church and Beta Theta Pi fraternity and was a

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**Reprints on Request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngo-
scope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp.
Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol.
35, 6-1-25, No. 11, 590-592.

veteran of World War I. Surviving are his widow, two daughters, three sons and his father.

Jeptha Marion Olin, M. D., Vermilion; Cleveland-Pulte Medical College, 1899; aged 85; died September 30; Dr. Olin practiced both in Vermilion and Cuyahoga Falls. Surviving is one son.

Lewis Augustav Oster, M. D., Hollywood, Fla.; University of Wooster, Medical Department, Cleveland, 1912; aged 60; died September 14. Dr. Oster practiced his profession in Cleveland before moving to Florida five years ago. He was active in several Masonic Orders. Among his interests was that of breeding thoroughbred horses. Surviving are his widow, a brother, Dr. Edwin J. Oster of Cleveland, and two sisters.

George Dimitre Popoff, M. D., Canton; University of Graz, Austria, 1929; aged 50; died September 11 in a St. Louis hospital; member of the Ohio State Medical Association and a Fellow of the American Medical Association; diplomate of the American Board of Radiology. Dr. Popoff was chief radiologist at Mercy Hospital since 1941 and was the author of many scientific works in his specialty. Surviving are his widow, three sons, two brothers and three sisters.

Cyrus Marion Rambo, M. D., Zanesville; Starling Medical College, Columbus, 1891; aged 85; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Muskingum County Medical Society in 1933. Dr. Rambo opened an office in Zanesville after completing his medical education and, in spite of his age, continued his practice on a limited scale until his death. He was a member of the Odd Fellows and the Elks Lodge. Surviving are his widow, a daughter, a brother and three sisters.

Jay Verne Rice, M. D., Wellsville; University of Louisville School of Medicine, 1910; aged 66; died September 1 in Birmingham, Ala.; former member of the Ohio State Medical Association and the American Medical Association through 1946. Dr. Rice practiced his profession for 42 years, about 20 years of which were spent in Wellsville, where he was health commissioner for many years. He retired about two years ago because of ill health and only recently moved to Birmingham. Surviving are his widow, two daughters, a sister and four brothers.

Raymond Wentworth Runyan, M. D., Panama City, Panama; Medical College of Ohio, Cincinnati, 1906; aged 63; died September 17. Dr. Runyan practiced for a short time in Cincinnati before going to Panama. He was a member of the Medical Association of Isthmian, Canal Zone, and a Fellow of the American Medical Association; member of the American College of Sur-

geons. Surviving are his widow, two sons, a brother and a sister.

Charles Henry Slosson, M. D., Youngstown; Cleveland University of Medicine and Surgery, 1888; aged 82; died September 30 in Cleveland; former member of the Ohio State Medical Association and the American Medical Association through 1938. Dr. Slosson practiced medicine in Youngstown for almost 60 years.

Robert Armstrong Smith, M. D., Ghent; McGill University Faculty of Medicine, Montreal, 1897; aged 78; died September 30; former member of the Ohio State Medical Association and the American Medical Association through 1947. After service during the Spanish-American War, Dr. Smith settled in Ghent where he practiced until his retirement two years ago. He was a member of the Masonic Lodge. Surviving is his wife by a second marriage.

Ernest Burdett Taylor, M. D., Toledo; Toledo Medical College, 1903; aged 69; died October 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Taylor practiced medicine in Toledo for 30 years after going there from Arcadia. A veteran of World War I, he was a member of the American Legion. Surviving are his widow, a daughter and two sons.

Trumbull County Schedules Postgraduate Day

The Annual Postgraduate Day of the Trumbull County Medical Society will be held on Wednesday, Nov. 17, at the Masonic Temple, Niles. Included will be an afternoon program beginning at 2 p. m., dinner at 6 p. m., and an evening program. Guest speakers are of the Medical College of Virginia, Richmond.

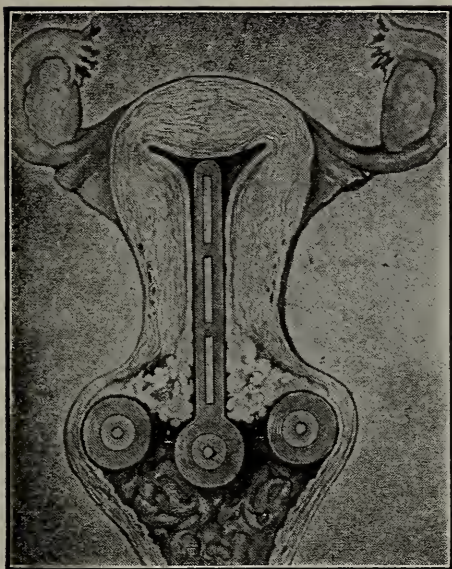
First afternoon session—Discussions of Hypertension: "General Survey and Classifications," Dr. W. Taliaferro Thompson, Jr.; "Medical Management of Hypertension," Dr. Elam C. Toone, Jr.; "Surgical Management of Hypertension," Dr. Guy W. Horsley.

Second afternoon session—"Gastro-Intestinal Bleeding": Diagnosis, Dr. Toone; Medical Treatment, Dr. Thompson; and Surgical Treatment, Dr. Horsley.

Evening program—"Fiedler's Myocarditis With Case Reports," Dr. Thompson; "Rheumatoid Spondylitis—Diagnosis and Management," Dr. Toone; and "Surgical Management of Benign Breast Tumor with Special Reference to Endocrine Therapy," Dr. Horsley.

The Ohio Department of Health will use a \$36,726 grant from the National Cancer Institute for study of industrial causes of cancer in the state, according to Dr. John D. Porterfield, director.

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A.M.A. Interim Session . . .

Demonstrations by Television To Be Among Features at National Scientific and Business Meeting in St. Louis, Nov. 30 - Dec. 3

ALL American Medical Association Interim Session activities—meetings of the House of Delegates, general lectures, clinical presentations, scientific exhibits, technical exhibits, motion pictures and television—will be concentrated in the Kiel Auditorium in St. Louis. The A.M.A. Interim Session will open in St. Louis on Tuesday, November 30, and continue through Friday, December 3.

The program includes a general session on Tuesday and Thursday evenings with outstanding entertainment on Wednesday evening. The second annual General Practitioner award will be presented on Thursday evening.

Registration will begin Tuesday morning and the meetings will close at noon on Friday.

The St. Louis Local Committee on Arrangements, which has been very active, is headed by Dr. Robert E. Schlueter and Dr. Llewellyn Sale, is serving as co-chairman. Subcommittee chairmen are: Drs. Flavius G. Pernoud, hotels; Robert F. Hyland, transportation; Robert C. McElvain, information and registration; and Cyrus E. Burford, general meeting.

The Subcommittee on Scientific Meetings is headed by Dr. Alphonse McMahon, chairman, and Dr. Daniel L. Sexton, co-chairman.

SCIENTIFIC PROGRAM

The scientific program will begin at 2 p. m. Tuesday with two half-hour periods of lectures. After a brief recess, clinical presentations, many of them with patients, will be conducted in seven rooms in the Scientific exhibit hall. Exhibits pertaining to the clinical presentations will be shown in areas outside each room. The same procedure will be followed each morning and afternoon.

The program on diabetes will be in charge of Dr. Howard F. Root, Boston, with Dr. William H. Olmsted, St. Louis, serving as local chairman. Clinical presentations will be conducted from 10 a. m. to 1 p. m. and from 3:30 p. m. to 5 p. m. on Wednesday and Thursday. Dr. Elliott P. Joslin, Boston, will summarize the subjects at 9:30 a. m. on Friday.

The cancer program will be in charge of Dr. Brewster S. Miller of the American Cancer Society, New York, with Dr. Sherwood Moore, St. Louis, as local chairman. The general lecture on cancer will take place at 9 a. m. Friday and clinical presentations from 3:30 to 5 p. m. on Tuesday, Wednesday and Thursday.

The poliomyelitis program is being handled by

Catherine Worthingham of the National Foundation for Infantile Paralysis, New York, and Dr. Sedgwick Mead, St. Louis, is the local chairman. The program, which calls for elaborate presentations on the diagnosis and treatment of the disease, will be repeated daily at 10:30 a. m. to 12 noon, and 3:30 to 5 p. m. The general lecture will be given at 2 o'clock on Thursday afternoon.

The program on cardiovascular diseases has been arranged by Dr. O. P. J. Falk, St. Louis, the local chairman. A general lecture on hypertension will be given at 2 p. m. Tuesday with clinical presentations from 3:30 to 5 p. m. A lecture on heart disease will be given at 2:30 p. m. Thursday with clinical presentations on Wednesday and Thursday afternoons from 3:30 to 5:00.

OBSTETRICAL CLINICS

The subject of obstetrics will be confined largely to the problems of delivery. Dr. Arthur B. Hunt, Rochester, Minn., the coordinator, and Dr. Joseph A. Hardy, Jr., St. Louis, the local chairman, have arranged for clinical presentations on Tuesday, Wednesday and Thursday afternoons, with a general lecture at 2:30 p. m. Tuesday.

The clinical presentations on pediatrics will be conducted Wednesday, Thursday and Friday mornings from 10:30 to 12:00, with the general lecture at 9 a. m. on Wednesday. Dr. Hugh McCulloch is the coordinator and Dr. Peter G. Danis, St. Louis, the local chairman.

Laboratory diagnosis will be in charge of Dr. Frank W. Konzelmann, Atlantic City, and Dr. Robert A. Moore, St. Louis, is the local chairman. Clinical presentations will be given each morning and afternoon throughout the week, while continuous demonstrations will be conducted by members of the St. Louis Pathological Society in a laboratory adjacent to the clinic room. Dr. Konzelmann will present the general lecture at 9:30 Wednesday morning.

DERMATOLOGY

Dermatology, in charge of Dr. Clinton W. Lane, St. Louis, the local chairman, will be covered in clinical presentations on Wednesday, Thursday and Friday mornings. The general lecture will be given at 2:30 p. m. Wednesday.

The program covering hematuria includes clinical presentations on Wednesday, Thursday and Friday mornings, with a general lecture at 9 o'clock Thursday morning. The coordinator is Dr. Edward N. Cook, Rochester, Minn., with Dr.

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Grayson Carroll, St. Louis, serving as local chairman.

The jaundice program is under the direction of Dr. Sidney A. Portis, Chicago, and Dr. R. O. Muether, St. Louis, is the local chairman. Clinical presentations will be conducted Thursday morning and afternoon and Friday morning. The general lecture will take place at 9:30 a. m. Thursday.

Clinical presentations on radiology will be covered Tuesday afternoon and Wednesday morning and afternoon and will be in charge of Dr. Paul C. Hodges, Chicago, as coordinator and Dr. Wendell G. Scott, St. Louis, as local chairman.

The subject of arthritis, under the direction of Dr. C. H. Slocumb, Rochester, Minn., with Dr. Ralph A. Kinsella, St. Louis, as local chairman, will be discussed in a general lecture at 2 o'clock Wednesday afternoon with clinical presentations on Tuesday afternoon from 3:30 to 5:00 and on Friday morning from 10:30 to 12:00.

With the cooperation of the St. Louis University School of Medicine and Washington University School of Medicine, television will be shown continuously. The committee in charge consists of the Rev. Alphonse M. Schwitalla and Dr. Robert A. Moore, St. Louis.

The Scientific Exhibit will consist of groups of exhibits covering all these subjects as well as miscellaneous topics.

Motion pictures will be shown daily from 12 noon to 3:30 p. m., with a carefully chosen list of films selected by the Committee on Medical Motion Pictures of the A. M. A.

Residency Program in Psychiatry Approved for O. S. U.

A residency training program in psychiatry has been approved for the Department of Neurology and Psychiatry, Ohio State University, Columbus, and the Chillicothe Veterans Hospital at Chillicothe, Ohio. Approval has been given to this program by the Veterans Administration, the American Medical Association and the American Board of Psychiatry and Neurology.

A 36-month training program is projected and instruction and experience will be offered in all areas of psychiatry. The program will be supervised by a Deans Committee for Neuropsychiatry from the College of Medicine at Ohio State University. This committee is composed of Dr. Charles A. Doan, dean, member ex officio; Drs. Dwight M. Palmer, chairman; Harry E. LeFever, Harrison Evans, Nicholas Michael, and E. J. Humphreys.

Eighteen months of residence will be at Chillicothe and 18 months in Columbus.

Anyone interested in this Residency Program should write to Dr. Dwight M. Palmer, Department of Neurology and Psychiatry, Ohio State University, Columbus 10, Ohio.

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Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

At the Oct. 20 meeting of the Adams County Medical Society, Dr. Martin H. Fischer, Cincinnati, spoke on "Hypertension and Its Therapy."

HAMILTON

Dr. Edward Tolstoi, Cornell University Medical College, spoke on the subject, "Treatment of Diabetes Mellitus—the Controversy of the Decade," at the Oct. 5 meeting of the Academy of Medicine of Cincinnati. Arrangements have been made to have the College of Medicine Library (University of Cincinnati) open until 8:30 p. m. on Academy meeting nights.

On Oct. 19 Dr. Paul C. Bucy, University of Illinois, Chicago, spoke on "The Simulation of Degenerative Disease by Compression of the Spinal Cord by Herniated Cervical Intervertebral Discs."

Highlights of coming programs are the following:

Nov. 9—Dr. Carl V. Moore, Washington University School of Medicine, St. Louis, "Therapeutic Uses of Radioactive Isotopes."

Nov. 23—Dr. Paul W. Greeley, University of Illinois, "The Role of Plastic Surgery in Treating Various Dermatological Lesions."

Dec. 7—Dr. Barry Wood, Washington University School of Medicine, "Defense Mechanisms of the Host in Relation to the Chemotherapy of Acute Bacterial Infections."

Dec. 21—Dr. A. C. Ivy, University of Illinois College of Medicine, "The Principles of Therapy of Peptic Ulcer."

Jan. 4—Dr. A. J. Patek, Jr., Columbia University, "Treatment of Liver Diseases."

Jan. 18—Dr. Alvin L. Barach, Columbia University, "Recent Advances in the Treatment of Diseases of the Chest."

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

"Management and Treatment of the Alcoholic Patient," was discussed by Dr. Nicholas Michael, Ohio State University College of Medicine, at the Oct. 18 meeting of the Clark County Medical Society in Springfield.

DARKE

"Aspects of Rheumatic Fever" was the topic of a talk by Dr. Arthur H. Spreen of Cin-

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RADIOLOGY

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cinnati at the October 19 meeting of the Darke County Medical Society in Greenville.

MIAMI

The regular meeting of the Miami County Medical Society was held at the Stouder Hospital, Troy, on Oct. 8, where Dr. Anson L. Brown, Columbus, presented a paper on "Essential Laboratory Procedures for the General Practitioner." Dr. Roger M. Gove, Piqua, reported on activities of the Miami County mental hygiene project which has been in operation about one year.

MONTGOMERY

Dr. B. N. Carter, University of Cincinnati College of Medicine, spoke on "Early Detection of Cancer of the Breast," at the Oct. 8 meeting of the Montgomery County Medical Society in Dayton. Dr. Warner Peck, also of the University of Cincinnati, displayed an exhibit on cancer of the breast.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M. D.,
UPPER SANDUSKY)

ALLEN

Officers of the local unit, American Cancer Society, were guests of the Academy of Medicine of Lima and Allen County for the Sept. 21 meeting at the Shawnee Country Club, Lima. Dr. F. A. Hemsath was in charge of the program on cancer.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M. D., TOLEDO)

LUCAS

The October program of the Academy of Medicine of Toledo and Lucas County was as follows:

General meeting, Oct. 1—"My Experiences in Diabetic Acidosis," Dr. Russell Wilder, Rochester, Minn.

Section on Pathology, Experimental Medicine and Bacteriology, Oct. 8—"Discussion of the Academy of Medicine Vaginal Smear Program," by a panel of speakers.

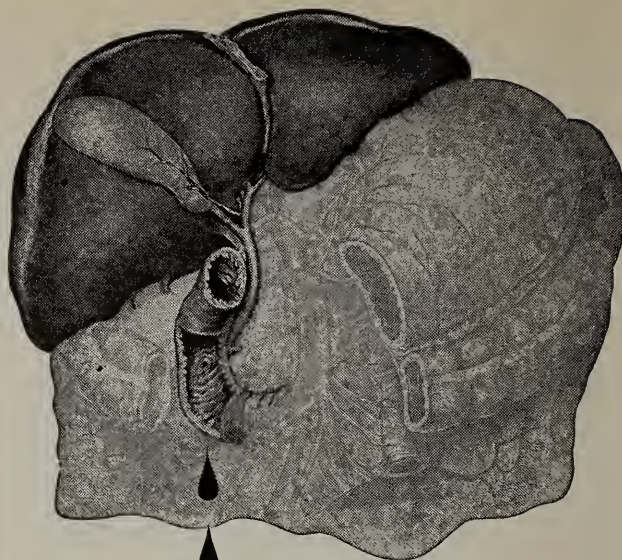
Medical Section, Oct. 15—"Recent Advances in Virus Diseases," Dr. John H. Dingle, Western Reserve University School of Medicine, Cleveland.

General Practice Session, Oct. 19—"Office Management of the Diabetic," Dr. L. A. Levison of Toledo.

Section of Specialties, Oct. 29—"Round Table Discussion of Diabetes," by Drs. David C. Frick, Raymond E. Boice, Richard Hotz, and Edward F. Ockuly, all of Toledo.

PUTNAM

Dr. Paul Q. Peterson of the Ohio Department of Health, Columbus, spoke on the subject



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.



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of poliomyelitis at the Oct. 12 meeting of the Putnam County Medical Society in Columbus Grove.

SANDUSKY

Guest speaker of the Sandusky County Medical Society meeting on Sept. 11 was Dr. Albert L. Bershon of Toledo who spoke on the topic "Poliomyelitis."

WOOD

The Wood County Medical Society resumed its meetings after the summer vacation on September 16 at Don's Point Restaurant. At the business meeting following the dinner it was resolved to recommend deferment of tonsillectomies until after a decline of the polio increase. Dr. A. E. Rhoden, pathologist at Flower Hospital gave the paper of the evening on "Surgical Pathology of the Female Genitalia." He organized his material about a series of unusually good kodochrome slides of gross pathology beginning with the vulva and ascending through the tract. Emphasis was laid on early recognition of the various lesions by the general practitioner and proper care of the case.

This was followed by a discussion of the Papanicolaou procedure and its relation to the classic biopsy. The brisk question period following the presentation attested to the live interest created by the paper.

At the meeting on October 21, Dr. Harlan F. Howe of Toledo spoke on "Gastric Ulcer."

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

The Oct. 8 program of the Academy of Medicine of Cleveland included the following presentations from studies of Drs. William D. Holden, Donald B. Cameron, Patrick J. Shea, Jr., Byers W. Shaw, John W. Cole, and John H. Davis, Jr., all of Western Reserve University School of Medicine:

"Trypsin and Thrombin Induced Venous Thrombosis and Its Prevention With Dicumarol," presented by Dr. Shaw.

"Clinical Studies of the Heparin Cofactor," presented by Dr. Cole.

"Experimental Pulmonary Embolism," presented by Dr. Holden.

The Obstetrical and Gynecological Section met on Oct. 26 at which time Dr. R. W. Marsters spoke on "The Rh Factor in Obstetrics," and Dr. Viola V. Startzman discussed, "Replacement Transfusion of the Erythroblastotic Baby."

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

COLUMBIANA

"Low Back Pain" was the subject discussed by Dr. Kay E. Liber of Canton at the Sept. 21



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GYNECOLOGY—Intensive Course, two weeks, starting Feb. 21, March 21. Vaginal Approach to Pelvic Surgery, one week, starting Feb. 14.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4. Personal Course in Gastroscopy, two weeks, starting April 18.

DERMATOLOGY—Formal Course, two weeks, starting April 18. Clinical Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

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meeting of the Columbiana County Medical Society.

MAHONING

Dr. Bradley L. Coley, Cornell University Medical College was guest speaker at the Sept. 21 meeting of the Mahoning County Medical Society. His subject was bone tumors.

PORTAGE

Dr. Edward L. Voke, Akron, addressed the Portage County Medical Society on Oct. 7 at Ravenna on the subject "Silicosis and Tuberculosis."

STARK

On Sept. 15, the Stark County Medical Society met at the Shady Hollow Country Club, where Dr. Eugene Hamilton, Loyola Medical School, Chicago, spoke on "Care of Fractures."

TRUMBULL

"Present Status of Treatment of Diseases of the Thyroid," was the topic of a talk by Dr. George W. Crile, Jr., Cleveland, at the September meeting of the Trumbull County Medical Society. A joint dinner with members of the Woman's Auxiliary was held after which the groups held separate meetings.

Seventh District

(COUNCILOR: R. J. FOSTER, M. D., NEW PHILADELPHIA)

BELMONT

A dinner meeting with the Woman's Auxiliary was held by the Belmont County Medical Society at Belmont Hills Country Club on Oct. 21. Guest speaker was Dr. Louis J. Karnosh of Cleveland.

Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

WASHINGTON

Dr. Chester P. Swett, Lancaster, Eighth District Councilor, was guest speaker at the Sept. 8 meeting of the Washington County Medical Society at Hotel Lafayette, Marietta.

Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

SCIOTO

Special speaker for the Oct. 11 meeting of the Hempstead Academy of Medicine in Portsmouth was Dr. John A. Caldwell, Cincinnati, who spoke on "Local Anesthesia in the Management of Fractures."

Tenth District

(COUNCILOR: H. M. CLODFELTER, M. D., COLUMBUS)

FRANKLIN

The October program of the Columbus Academy of Medicine was as follows:

Oct. 4—"Prophylactic Treatment of Infectious Diseases in Children," a panel discussion by

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members of the staff of Children's Hospital with Dr. Earl H. Baxter as chairman.

Oct. 18—A symposium by members of the staff of Grant Hospital. The program included "Surgical and Medical Aspects of Vagotomy" by Dr. William B. Morrison and Dr. William F. Bradley, and "Rupture of the Uterus" by Dr. Dana W. Cox.

Eleventh District

(COUNCILOR: JOHN S. HATTERY, M. D., MANSFIELD)

LORAIN

"The Rh Factor in Obstetrics," was the subject of a talk by Dr. Foster Myers of Toledo at the Oct. 12 meeting of the Lorain County Medical Society at the Pueblo, Lorain.

WAYNE

The Eleventh District Councilor and his wife, Dr. and Mrs. John S. Hattery of Mansfield, were guests of the Wayne County Medical Society for the annual picnic at Applecreek on Oct. 6

Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER
Chairman, Publicity Committee

BUTLER

Antiques from the collection of Mrs. E. Norwood Clark graced the tables at Manchester Hotel, Middletown, when the Woman's Auxiliary to the Butler County Medical Society met for luncheon on Tuesday, September 28. Following a brief business session in charge of Mrs. Azel Ames, president, Dr. J. N. Christianson was introduced as the speaker of the day. Dr. Christianson spoke on the need in Butler County for adequate care of tubercular patients. He pointed out the extreme need for a new county hospital. The auxiliary sponsored a luncheon and fashion show at Anthony Wayne Hotel, Hamilton, on October 12. The proceeds will go to the Tuberculosis Sanitorium.

CLARK

The Woman's Auxiliary to the Clark County Medical Society launched its activities for the year at a tea in the home of Mrs. S. C. Yinger, when the new president, Mrs. Frank Anzinger, Jr., assumed her duties and appointed committees. The 1948-1949 program as outlined by the president, will follow closely the programs of the State and National Auxiliaries. Announcement was made that the board again had voted to continue working on the point system. It was also reported that the scholarship loan had been awarded to a young Springfield woman who will study nursing in the Springfield Hospital School of Nursing.

COLUMBIANA

Mr. Harold Zealley, superintendent of the Salem City Hospital, reviewed his trip to Switzerland and illustrated it with movies for members

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1. Paul, W. D., and Montgomery, A. E.: J. Iowa State M. Soc. 38: 237 (June) 1948.

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SEYMOUR

INDIANA



of the Columbiana County Medical Society and its Auxiliary at a dinner meeting held recently in Park View Inn, Canfield. Places were arranged for forty-four.

ERIE

A luncheon at Plum Brook Country Club marked the opening of the year for the Woman's Auxiliary to the Erie County Medical Society. This auxiliary, now in its second year, will be guided in its activities this season by Mrs. W. T. Fenker, president; Mrs. Carl E. Swanbeck, president-elect; Mrs. E. J. Meckstroth, vice-president; Mrs. H. W. Lehrer, secretary; and Mrs. A. R. Grierson, treasurer. Mrs. Ross M. Knoble is past-president.

FAIRFIELD

The Woman's Auxiliary to the Fairfield Medical Society was hostess to the Eighth District meeting in Lancaster, September 24, at Hotel Lancaster. A luncheon opened the session. Mrs. Chester P. Swett, Eighth District director, presided. Mrs. E. Benjamin Gillette, state president, Mrs. C. W. Kirkland, state president-elect, and Mrs. George W. Cooperrider, state vice-president, were guest speakers.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine opened the fall season with a luncheon party at the Columbus Gallery of Fine Arts on September 20. A feature of the afternoon was the presentation of a gavel from the Columbus Academy of Medicine by its president, Dr. Harve M. Clodfelter. Meetings for the year have been arranged around the theme of the varied activities of the busy doctor's wife. Programs for September and October were: "The Doctor's Wife Goes to a Party," and "The Doctor's Wife Sees Herself." Other scheduled programs are: November, "The Doctor's Wife Lends a Helping Hand"; December, "The Doctor's Wife Dines With the Doctor"; January, "The Doctor's Wife Ages Successfully"; February, "The Doctor's Wife Learns To Read"; March, "The Doctor's Wife Hears 'Music in the Community'"; April, "The Doctor's Wife Attends a Convention"; and May, "The Doctor's Wife Rests on Her Laurels."

KNOX

The silver tea given by the Woman's Auxiliary to the Knox County Medical Society in the home of Mrs. Julius Shamansky was an enjoyable social function for the members and their guests. Proceeds were used in decorating and furnishing the nursery in Mercy Hospital. The program included two vocal numbers and a talk by Mrs. Wallace Rigby who told of her work as a "ghost writer" with Duncan Hines. Mrs. Charles Tramont, president of the auxiliary, presided at the tea table. At the September meeting the work and activities of two sewing guilds were planned for the coming months.

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LICKING

When the members of the Woman's Auxiliary to the Licking County Medical Association met for dinner in Harbor Hills Inn, Miss Rosemary Kuster, a graduate of St. Francis de Sales High School, was presented with a scholarship. The auxiliary will sponsor a scholarship annually to the outstanding student in the Newark Hospital School of Nursing. Miss Kuster was the recipient of the first award given by the group.

PICKAWAY

Members of the Woman's Auxiliary to the Pickaway County Medical Society opened their fall and winter meetings with a luncheon Tuesday, September 28, in the Pickaway Arms. Mrs. Lloyd Jonnes, president, was in charge of a business session following the luncheon. The group, with the Ohio State Medical Association, cosponsored a booth at the Circleville Pumpkin Show for educational purposes.

RICHLAND

Forty-one members of the Woman's Auxiliary to the Richland County Medical Society convened Monday afternoon at the Women's Club to open the 1948-1949 season. Hostesses were Mrs. Charles L. Shafer and Mrs. Dwight Weir. Luncheon was served. Mrs. Carl Damron, president, presided at the business session. Programs for the year were distributed. Mrs. C. H. Bell gave a report of the National meeting, held in Chicago in June. During the social hour, bridge was the diversion. On October 13, the Richland County doctors and their wives met for a dinner party at Westbrook Country Club.

SCIOTO

A garden party at the home of Mrs. H. M. Keil, opened the fall meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine. Twenty-six members were present. Programs for the coming year were distributed and a social hour followed reports of the standing committees.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society met for luncheon at the Woman's City Club of Akron on October 5. Following luncheon, Mr. George H. Saville, director of public relations for the Ohio State Medical Association, gave excellent advice concerning "What Every Doctor's Wife Should Know About Public Relations."

UNION

The Woman's Auxiliary to the Union County Medical Society met for luncheon at the Dinner Bell. Mrs. Albert Johnston presided at the business meeting. Announcements regarding

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the autumn activities of the State Auxiliary were read and local committee appointments for the coming year were announced as follows: Mrs. Angus MacIvor, publicity and public relations chairman; Mrs. James Snider, program chairman; Mrs. Pearl D. Longbrake, social chairman. Other officers include Mrs. B. E. Ingmire, Plain City, vice-president; Mrs. Fred Callaway, Marysville, president-elect; and Mrs. E. J. Marsh, Broadway, secretary and treasurer. A sum of \$101 has been turned into the Hospital fund, the auxiliary's project for last year.

Academy of Dermatology and Syphilology To Meet

The seventh annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago from Saturday, December 4, through Thursday, December 9, it was announced by Dr. Earl D. Osborne, secretary-treasurer of the Academy, 471 Delaware Ave., Buffalo, N. Y.

The principal sessions will be held at the Palmer House, with special courses in histopathology and mycology scheduled for Saturday and Sunday, December 4 and 5, at the Medical Schools of the University of Illinois and Northwestern University. As in the past two years, teaching clinics will be held on the afternoons of Monday, Tuesday, and Wednesday. A new feature is being added to the program this year consisting of informal discussion groups, which will be held at noon and 5 p. m. sessions.

Extensive scientific and technical exhibits will be set up in connection with the meeting.

Special courses in histopathology, mycology, X-ray and radium therapy, mucous membrane lesions, bacteriology of the skin, industrial dermatoses, specific granulomata, and dermatoscleroses will be held under leaders in those various fields.

Other officers of the Academy are: Dr. Clyde L. Cummer, Cleveland, president; Dr. Francis E. Senear, Chicago, Ill., vice-president; and Dr. John E. Rauschkolb, Cleveland, assistant secretary-treasurer.

Chicago Medical Society

The Fifth Annual Clinical Conference of the Chicago Medical Society will be held in Chicago at the Palmer House, March 1, 2, 3, and 4, 1949. Well-known speakers from all sections of the country will discuss subjects of interest to all physicians. Many scientific exhibits are being planned and the technical exhibits will be well displayed.

Physicians of Ohio and other states and cities are invited to attend. Reservations should be made direct with the Palmer House.

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Buckeye News Notes . . .

Alliance—Dr. William A. McCrea is the new city health commissioner.

Ashland—"Infantile Paralysis" was discussed by Dr. C. B. Meuser, health commissioner, at a recent meeting of the Ashland Rotary Club.

Canton—Dr. John D. O'Brien addressed a recent meeting of the Co-operative Club on the subject of mental hygiene.

Cardington—Dr. F. M. Hartsook is the chairman of the new Morrow County draft board.

Cincinnati—Dr. Frank R. Dutra, pathologist for the Kettering Laboratory of Applied Physiology, University of Cincinnati, and for the Hamilton County coroner's office, has accepted a position as medical examiner of Westchester County, New York, effective in January.

Cincinnati—Dr. Gerald H. Castle has been appointed medical officer in command of Reserve Medical Division No. 9-39 U. S. Navy, which has Cincinnati as its center.

Columbus—Dr. Robert E. S. Young attended the Ninth International Congress of Industrial Medicine in London, England, during September.

Covington—Dr. John M. Wilkins of Covington was appointed to fill the vacancy on the Miami County Board of Health caused by the resignation of Dr. Claire E. Stout of West Milton.

Dayton—Dr. Franklin I. Shroyer attended a meeting of the Mississippi Valley Medical Society in Springfield, Ill., where he was honored for his scientific paper on early diagnosis of neoplastic growth in the female pelvis.

Dayton—Dr. Frank C. Sutton, formerly medical director of the Rochester (N. Y.) General Hospital, took over his duties as director of the Miami Valley Hospital early in October.

Hillsboro—Dr. Clifford G. Foor was appointed to the Hillsboro School Board.

Mansfield—Dr. R. R. Black has been appointed to the city board of health.

Medina—Dr. T. Victor Kolb, Litchfield, is the new Medina County coroner, succeeding Dr. Theodore A. Gross who recently resigned.

Middletown—"Kiwanis Is Big Business," according to Dr. Clifford S. Palmer of Massillon who used that subject in a talk before the Middletown Kiwanis Club.

New Philadelphia—The Tuscarawas County Council of Religious Education endorsed the proposed county health program at a recent meeting following a talk by Dr. Clark M. Dougherty.

Youngstown—President of the newly organized Youngstown Area Heart Association is Dr. W. H. Bunn, and vice-president is Dr. R. B. Poling.

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Advisory Committee on Maternal And Child Health Named

Three Ohio persons, including two physicians, are on the 47-member advisory committee on maternal and child health and crippled children's services.

Representatives of the professions and the general public met during September in Washington to form the advisory committee to the U. S. Children's Bureau on Federal-state programs for maternal and child health and crippled children's services.

Included on the committee are Dr. Charles F. Good, County Health Department, Cleveland, directing supervisor, health service, Board of Education; Dr. Thomas E. Shaffer, Ohio State University, Columbus, school physician, The University School, representing the American School Health Association; and Mrs. Eva Ylvisaker, Children's Hospital, Cincinnati, chief dietitian, representing the American Dietetic Association.

Representatives of the American Medical Association on the committee are Dr. W. W. Bauer, Chicago, director of the A. M. A. Bureau of Health Education, and Dr. James R. Miller, Hartford, Conn., a member of the Board of Trustees.

COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22, 1949.

American Medical Association Interim Session, St. Louis, Nov. 30-Dec. 3.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9.

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9, 1949.

American Academy of Pediatrics, Atlantic City, Nov. 20-23.

American College of Physicians, Annual Session, New York City, March 28-April 1, 1949.

American Public Health Association, Boston, Mass., Nov. 8-12.

Eleventh Post-Collegiate Assembly, O. S. U. College of Medicine, Columbus, Dec. 11.

Interstate Postgraduate Medical Association of North America, 1948 Assembly, Cleveland, Nov. 9-12.

Medical Study Course, Ohio State University College of Medicine, Columbus, Dec. 6-11.

Trumbull County Medical Society, Postgraduate Day, Niles, Nov. 17.

Northwest Ohio Meeting Well Attended; Good Program Presented

Dr. W. W. Green, Toledo, was elected president of the Northwestern Ohio Medical Association at the 104th meeting of the association at Findlay College, Findlay, on October 5. Other officers elected were: Dr. Ralph E. Rasor, Findlay, vice-president; Dr. Floyd Yeager, Marion, secretary; and Dr. C. H. Evans, Jr., Findlay, treasurer. The 1949 meeting will be held in Toledo.

The scientific program was presented by Dr. Charles McKhann, professor of pediatrics, Western Reserve University, Cleveland; Dr. Henry Cromwell, instructor in medicine, Cornell Medical College, N. Y.; Dr. Charles W. Mayo, professor of surgery, Mayo Foundation, University of Minnesota; and Dr. Jonathan C. Meakins, dean and professor of medicine, McGill University, Montreal.

At the luncheon, the principal speaker was Dr. Paul R. Hawley, executive director, Blue Cross-Blue Shield Commission, on the subject, "A Realistic National Health Program." An address of welcome was made by Dr. H. Clifford Fox, president, Findlay College. Greetings from the Ohio State Medical Association were extended by Dr. J. Craig Bowman, Upper Sandusky, and Dr. Carl S. Mundy, Toledo, Councilors of the Third and Fourth Districts, respectively. Mr. Charles S. Nelson, executive secretary, Ohio State Medical Association, presented information regarding the progress made by Ohio Medical Indemnity, Inc., the voluntary prepayment plan sponsored by the State Medical Association, and on other activities being carried on by the Association. There was an attendance of almost 150.

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Beyond these major cost items, according to preliminary studies made by the Blue Shield national office in Chicago, approximately 70 surgical procedures will absorb 85 per cent of all payments to physicians for benefits provided under the average surgical type of subscriber contract.

* * *

The number of persons covered under Ohio Medical Indemnity, Inc., (Ohio Doctors' Plan) contracts as of September 30, was 416,774.

* * *

Michigan Medical Service reported 1,052,736 members enrolled at the end of the second quarter, 1948, becoming the first Blue Shield Plan to pass the million member mark.

Organized in 1939, Michigan Medical Service began operations in 1940, being one of the oldest of the Blue Shield Plans, and for many years the largest such Plan in the United States.

"According to our enrollment records, we expect United Medical Service in New York City to become the second Plan to pass the million mark before the end of 1948," declared Lynn Doctor, assistant director and statistician for the Blue Shield national organization.

* * *

With most of the nonprofit prepayment plans having reported their enrollment figures for the second quarter of 1948, the Blue Shield national office announced on August 1 that total enrollment had reached an estimated 8,624,911 members.

Second quarter growth was approximately 700,000 members, the largest quarterly growth ever recorded.

"At the present rate of growth, we expect the nonprofit plans to reach the 10,000,000 mark during the first quarter of 1949," reported Frank E. Smith, director of the Blue Shield national organization.

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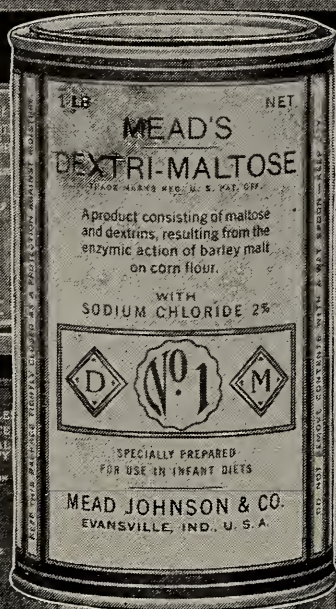
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The Physician's Bookshelf

By JONATHAN FORMAN, M.D.

Preoperative and Postoperative Care of Surgical Patients, by Hugh C. Ilgenfritz, M.D., (\$10.00. *C. V. Mosby, St. Louis*) brings out all of the new things in the care of the surgical patient that have become established through their proven usefulness. These involve the use of whole blood, plasma, and the crystalloid solution. This involves the detailed studies of the blood groups and a better understanding of the Rh factor; maintenance of fluid balance; prevention of deficiency states especially those due to protein loss. The use of chemotherapy is put on a more rational basis. The control of infections, hemorrhage, and shock thus as primary considerations in the recovery of the surgical patient receive adequate treatment. The emphasis placed upon the physiological basis underlying each step in the management of the surgical patient makes this work especially valuable.

The Universal Constant in Living, by F. Mathias Alexander, (\$2.50. *E. P. Dutton & Co., New York City*) is a book which some years ago received acclaim by such men as Aldous Huxley, John Dewey, G. Bernard Shaw, Sir Stafford Cripps, and others. The physical training of the British Army in the last year was based upon the principles which this author first formulated. The idea is to help the individual gain control over himself. It is a book which all who are so interested today in psychosomatic medicine should study.

Twentieth Century Speech and Voice Correction, edited by Emil Froeschels, M.D., (*Philosophical Library, New York City*) intends to offer to persons scientifically and/or practically interested in speech and voice correction, the latest developments in the field. Nineteen authorities contribute 22 chapters dealing with all phases of the subject. There is a great chance for knowledge in this field to contribute much to the social adjustment of mankind.

Failures in Psychiatric Treatment, edited by Paul H. Hoch, M.D., (\$4.50. *Grune & Stratton, New York City*) is a symposium which attempts to review the therapeutic failures with different psychiatric methods of treatment. It is gratifying to note that psychiatry has matured sufficiently to begin to take into consideration its own failures.

Fifty Years in Starch, by Anne A. Williamson, R.N., (\$2.75. *Murray & Gee, Inc., Culver City, California*) is the life story of one distinguished member of the nursing profession. This auto-

biography will serve as an inspiration to any young woman who has made up her mind halfway to become a nurse.

Handbook of Ophthalmology, by Everett L. Goar, M.D., (\$5.50. *C. V. Mosby, St. Louis*) is an excellent synopsis based upon the lectures for medical students at Baylor University.

Parents Can't Win, by Jim and Dorothy McGuinn, (\$2.75. *Pellegrini and Cudahy, Chicago, Ill.*) is a clever take off on child care books with extremely clever illustrations by Lucille Follmer.

Urological Oddities, by Wirt Bradley Dakin, M.D., (*Published Privately by the Author in Los Angeles, Calif.*) presents the entire collection of unusual case reports as a medical reference book leavened with occasional humorous anecdotes. For 15 years urologists and other physicians throughout the world have sent Dr. Dakin reports of unusual experiences and from time to time the author would issue "Believe-it-or-not Booklets" and distribute them to those who had thus contributed. Considerable interest in this was aroused among physicians and consequently this collection is extraordinarily large and valuable.

Teaching Psychotherapeutic Medicine, An Experimental Course For General Practitioners, (\$3.75. *The Commonwealth Fund, New York City*) tells the story of how 25 representative physicians from Minnesota and nearby states studied for two weeks with seven psychiatrists and two internists, the meaning and value of the patient-physician relationship, the natural history of the personality, the significance of psychoneurotic behavior, and the ways in which everyday practice can be made more helpful, by single psychotherapy—in brief, the art of helping people whose trouble is emotional as well as physical.

This was not strictly a talk feast but the men actually met patients in the out-patient department with headaches, indigestion, backache and all the rest that baffle the best at times. They came to feel as a result of this experience that with a greater understanding of human emotions and the physical expressions of emotional tension they could give better care to their patients and get greater satisfaction in the practice of medicine.

Certainly this work could be extended. If other state universities would undertake similar

courses of instruction for the rural practitioners it would insure a happier life for the physicians and better medical care for more people in rural areas. It has always seemed to your reviewer that one of the main reasons that rural practice was unsatisfactory to the average physician was that the only art of medical practice which he had was initiatively acquired. In other words, we train a young man in all of the science. So when he does every laboratory test and X-ray examination possible—literally throws the books at his patient—and comes up with no evidence of organic disease, the conscientious physician becomes a worried man. It is a tragedy to see these physicians lose their own emotional bearings and rush to specialization where if you cannot find your own type of organic lesions, you can always say, "This patient does not fall in my field."

General Endocrinology, by C. Donnell Turner, Ph. D., (\$6.75. *W. B. Saunders Company, Philadelphia*) has been written to meet the needs of beginning students who are concentrating upon experimental biology. The subject is therefore presented as a fundamental aspect of biologic science. Integrative mechanisms of an endocrine order are widespread among vertebrates, invertebrates, and even in plants. So endocrinology comes to be regarded as the science of chemical coordination of the organism and as such assumes a basic position in biology and becomes the subject of a course and this is the text for such a course at Northwestern University.

Medical Hypnosis, by Lewis R. Wolberg, M. D., Volume I, *The Principles of Hypnotherapy*, (\$5.50. *Grune & Stratton, New York City*) is devoted pretty largely to a step-by-step description of the induction process, illustrating various induction methods by excerpts from transcriptions of actual hypnotic sessions. There is a didactic discussion of the principles of psychotherapy, and the psychopathological features in different disease syndromes. The contributions that hypnosis has to make to the treatment plan are elaborated in some detail.

Practical Therapeutics, by Martin Rehfuss, M. D., F. Kenneth Albrecht, M. D., and A. H. Price, M. D., (\$15.00. *The Williams & Wilkins Co., Baltimore, Md.*) is a novel departure from most textbooks on therapy. It is the result of co-operation on the part of many members of the Jefferson Faculty. The emphasis on having a plan in the treatment of chronic illness and the graphic way such plans are presented makes the book most worth-while.

Cancer Manual, of The Cancer Committee of The Iowa State Medical Society, (\$1.00 from the Society) is the second edition of a compendium for the Medical Profession first published in 1937.

It proved so popular that over 50,000 copies were printed and distributed. It is interesting to note how much the interest of the public has been aroused in the intervening years. The entire budget of the American Society for the Control of Cancer was around \$200,000 and in 1947 the American people contributed to this society some \$14,000,000.

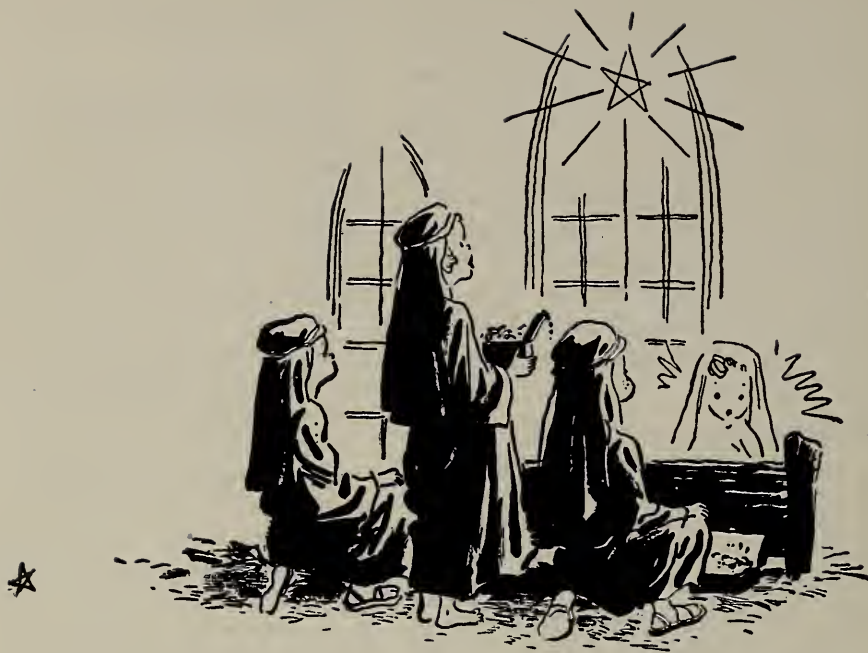
Dictators and Disciples, from Caesar to Stalin. A Psychoanalytical Interpretation of History, by Gustav Bychowski, M. D., (\$4.25. *International Universities Press, New York City*) is a serious and well-documented attempt to find an underlying principle. Instead of forcing opinions upon us, he lets history tell its own story.

By Their Fruits, The Story of Shakerism in South Union, Kentucky, by Julia Neal, (\$3.50. *University of North Carolina Press, Chapel Hill, North Carolina*). Anyone interested in co-operative communities and in the religious background of our mid-western culture, should read this book. Notes on the health of this community of Shakers are interesting. In general, it was remarkably good. The number of deaths from the cold plague of 1814-15 was surprisingly low. They appeared almost immuned to the Asiatic cholera epidemics of 1832-33 and 35. "During this time, the cholera raged along the rivers, the Shaker merchants were often on boats where passengers were dying of the malady. Yet, the brethren remained confident and unconcerned for themselves because they did not believe the Shakers would be attacked by it." Strangely, enough, only one of them ever died of the disease.

They had a smallpox scare in 1865 and an epidemic of a spotted fever in 1868. A third epidemic—this time scarlet fever—hit them in October, 1878.

The Shaker way of life is sadly missed in America today. No one of them felt that he had worshiped God right unless he was satisfied that the article that he was making was needed, would fit the purpose, and would last.

Modern Clinical Psychiatry, by Arthur P. Noyes, M. D., (\$6.00. Third Edition. *W. B. Saunders Company, Philadelphia*) is the first revision in eight years. Observations and popularization of psychobiological reactions of the human organism to the stress of war has stimulated a great desire on the part of student, physician, and patient to learn more concerning the manner in which people deal with their anxieties and frustrations inevitably attendant upon living. This volume now has the dynamic principles of the psychoneuroses presented in detail and much more about the psychosomatic expressions of the organism.



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Care of the Chronically Ill

JOSEPH I. GOODMAN, M.D.

PRIOR to 1939 the chronically ill indigents of all ages in Cuyahoga County were cared for in small privately run nursing homes. These were the familiar type of establishments set up principally for profit. Inasmuch as many of these homes had been condemned by the Fire Inspectors as firetraps, the patients were being moved frequently from place to place. Through the ingenuity and industry of Miss Bell Greve, who at that time was the director of the Cuyahoga County Relief Bureau, there was born The Cuyahoga County Nursing Home in Cleveland. Miss Greve reasoned that it ought to be possible to assemble these patients into a large, centralized nursing home. There were no extra funds for this purpose; yet from the very funds which constituted the allowances for these patients, old buildings owned by the County were redecorated, supplies ordered, and with running costs also included the Nursing Home was established. The resourceful Miss Greve was not satisfied with receiving 175 patients and letting them vegetate. She envisioned the employment of a trained physiotherapist, an occupational therapist, and a medical staff.

The Ohio State code provides as a prerequisite to admission that the patient must be totally and permanently incapacitated. Upon the admission of patients to the Nursing Home we pursue this policy: (1) To establish the diagnosis of their disability; (2) to determine where possible a course of rehabilitation; and (3) to strive to improve the mental as well as the physical well-being of each patient no matter how advanced the disease process may be. In the period of nine years there have been approxi-

The Author

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mately 1,000 admissions to the Nursing Home. Of these, about 200 have been discharged after treatment and were able to work or take care of themselves without nursing or medical care. A few examples will suffice: A man 28 years of age had fallen out of a window some months before admission. Having injured his spine and with one useless leg, he was adjudged by the referring hospital to the submarginal existence of invalidism. A sympathectomy improved the circulation of his leg and later with his ankle ankylosed he could walk and was discharged to take over a job at \$85 per week. We admitted a paraplegic woman with a diagnosis of syphilis but the disability proved to be caused by a herniated intervertebral disc and after operation she walked out cured. Another woman was known to have an ununited fracture of the hip and following an osteotomy she was discharged with only a slight limp.

A large number of patients were admitted with congestive heart failure. We developed a regime which allowed them (1) early ambulation, (2) unrestricted consumption of food and fluids and (3) the attainment of an edema-free state i.e., the basal weight level.^{1, 2, 3} Through this treat-

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ment the patients were converted from a bedridden to a relatively useful group.

NURSING CARE

The nursing care of these patients was developed by the nursing staff under the able direction of Miss Edith Marsh, author of "The Nursing Care of the Chronically Ill."⁴ Several of our patients have been bedridden and incontinent for over six years, yet the bedside care was so efficient, the personal nursing care so highly developed that bedsores did not occur. In cases presenting decubiti on admission every known type of treatment had been unsuccessful. Through a suggestion of our nursing supervisor, we developed a method using sulfathiazole powder topically which proved to be most effective in the healing of such resistant ulcers.⁵ Scrupulous attention to the patient's skin is still the best insurance.

These are some of the problems which we encountered, yet in my opinion the treatment of the chronically ill centers in the field of nutrition. If there is one deficiency common to this group it is malnutrition. Let us analyze a little further. Upon questioning each patient who is admitted to a chronic institution such as the Nursing Home one would learn that the dietary intake either prior to the onset of the illness—and most certainly afterwards—cannot be expected to support life for any length of time. What are the factors which contribute to the general poor state of nutrition in these people? In normal persons the amount of food which is consumed is determined from the time of infancy by the dictates of their appetites. Fortunately, the appetite rarely fails as a guide to sufficient food intake to supply the energy requirements of the body. Further, the appetite becomes associated in one's mind with the pleasant experiences of meal time. It is small wonder then that human beings lose their appetites under unhappy conditions, from stress and strain or during illness.⁶ All of us have had this experience. There can be little doubt that one of the major effects of a chronic illness is the loss of appetite and the concomitant reduction in the intake of food.

When sick patients do take food they are usually given fruit juices and so-called soft foods which will produce a deficiency if continued over any long period of time. More than likely a large proportion of chronically ill patients actually die of malnutrition before they would have expired from the basic organic disease. In other words their only guide to proper nutrition—the appetite—has failed. If the inadequate intake prevails in these individuals, ultimately a state is reached in which they are no longer able to withstand the inroads of illness, injury, operation, and the like. In dealing with indigents there is a special problem other than

the diminution of appetite whether by gradualism or stress it is an economic one. Briefly it can be stated that in general the food allowance of indigents makes it difficult for them to purchase the more essential articles required for an adequate diet. Another problem is that a great number of persons have developed finicky eating habits and usually their omissions include the most nutritious elements of the well-balanced diet.

DIETARY SURVEYS

We are justifiably concerned about the diet of the starving European and Asiatic, but dietary surveys would show that an alarming percentage of aged and chronically ill patients are undernourished. This fact can only be ignored by deliberately closing our ears. Yet it is true that our sick people are permitted to select for themselves the quality and quantity of their diets the total caloric and nutritional value of which cannot be expected to sustain life. This appalling situation is not reflected in mortality tables inasmuch as the attending doctor usually records as the cause of death not the precipitating malnutrition and the inability of the body to withstand an infection, disease, fracture, operation, etc., but the more obvious organic disease which may only be incidental to the exitus of the patient. To emphasize some of these points the following case is described.

CASE REPORT

A patient, aged 92, was admitted to the Cuyahoga County Nursing Home through the social service. He had been living with a son, aged 72, and both were on relief. The son was suffering from arthritis and as he became gradually more disabled, was no longer able to care for the older man. Subsequently the father suffered a stroke and had to be admitted as an "emergency case." In examining this aged man it was immediately apparent above everything else that we were dealing with an advanced state of starvation. He displayed no evidence of organic disease. The skin was shrivelled, dry, scaly and the muscles were so atrophied that he was unable to stand up or sit up without assistance. All of this in our opinion was directly correlated with the effects of subnutrition. How this state of affairs came about we learned through the social service investigation. It developed that because of the progressive disability of the son (in fact the older man actually waited on him) there was no one available to buy the food with their allowance of \$26 per month for both. Latterly they had subsisted on a few crackers and an occasional piece of bread per day.

The diagnosis was relatively simple in comparison with the treatment. Inasmuch as the starvation was predominant it was necessary to counteract the ravages by feeding him. During the next two days with much coaxing he succeeded in consuming one small glass of orange juice each day, a matter of 40 or 50 calories, which in fact was less than he took at home. To permit the old man to die in peace, which he surely would have done with a *laissez faire* ap-

proach, very likely would have passed unstigmatized by society; however the decision was made to enforce a feeding program. A Levine tube was inserted and large quantities of an appropriate high caloric mixture was injected every hour day and night. After less than twenty-four hours he was willing to take food by mouth and he continued to eat well, despite the fact that he developed pneumonia two days after admission. We were fearful that this infection, usually fatal in the aged, would end our feeding experiment. However, two months afterwards he was sitting up and taking his own meals. Though his admission weight was not known the weight at this time was 90 pounds and he was over six feet tall.

DISCUSSION

I have dwelt at length with nutrition because it is my opinion that herein lies the most important basis for all rehabilitation. Strangely enough though most institutions provide on paper and even on the patient's tray a fully adequate diet, in most cases the food had just as well not been served or cooked; it ends in the garbage can. The responsibility rests on the medical staff, the nurses, attendants, and administrative heads to retrain the patients to normal eating habits. Often one must convince the patient that he must not regard this as food per se but think of it in terms of medication for his particular disease. Whatever means are necessary must be utilized to accomplish the end. The results which can be expected from the successful application of the principles which I have only touched upon will be most gratifying and in many instances actually startling as is seen in the above case.

THE CHRONICALLY ILL

Some of the teaching hospitals have recently become aware of the importance of chronically ill patients and actually plan to establish special wards for "chronics." Certain general hospitals are planning along similar lines. However the question arises: What happens to patients who admittedly require continuous medical and nursing care after the acute hospitals have done what they can for them? In my experience it is the nature of the long-time and continuous care which determines the ultimate fate of the chronically ill patient. Because it is time consuming the final rehabilitation of such patients must be performed in an institution set up for this purpose alone rather than being decentralized in the general hospitals.

What may a chronic disease hospital offer patients suffering with incurable illnesses? There is little doubt that the patients who spend their entire existence under the surveillance of a hospital staff gain by comparison with those who live on the outside and are merely checked occasionally in a dispensary or by a visiting physician. Many outpatients are truly suited for

continuous hospital care but usually for a lack of facilities stumble along until they develop an acute illness or a relapse of the chronic one which is often fatal and might have been averted by hospitalization. In a chronic hospital the patient can often be improved by nursing care alone to the extent that he is able to attain a degree of both physical and mental comfort which makes his existence quite bearable. The nursing staff which has developed a sense of responsibility toward the hopelessly ill patient stands apart from those usually observed in acute hospitals. A sense of devotion far beyond the call of duty grows upon these nurses. They learn the peculiarities and are accordingly alert to the slightest variation in the behavior and health of their patients. Their task is not one of raising the morale of persons who have a fruitful life to look forward to but, on the contrary, they know full well—as does their patient—the utterly futile outlook in each case; yet they have the conviction to carry on against these great odds.

SPECIAL THERAPY

A similar situation prevails in the case of the physiotherapists and occupational therapists. Even the slightest improvement in the movement of an arm or a leg or relief of pains in arthritis is an attainment of which both the patient and the persons who have helped to bring this about are proud. The achievements in occupational therapy have become increasingly acknowledged and appreciated by the public. A small, but significant bit of work of which I have always been proud was performed by a patient with muscular dystrophy who was totally unable to lift his arms off the table. Despite this handicap he contributed charts and tables for several of my publications. The directors of general hospitals have frequently made the statement that they would not hesitate to admit chronic cases for proper study and treatment if they were given the assurance that the patient had a bed waiting for him either in an institution like The Nursing Home or in a chronic hospital. As a consequence not only would the patients be kept longer in the general hospital, but also the hospital staffs would benefit from the knowledge gained in studying chronically ill patients over long periods of observation.

Probably the foremost problem today confronting the homes for the aged is that of the chronically ill persons and the provision of skilled nursing and medical care. The families of these aged usually wait until the chronic illness has appeared before seeking admission for them into the home for the aged. The principal function of such an institution should be to provide custodial care, companionship and diversion for the average well old person and medical care for the run of mine complaints which arise. They

are not equipped for and should not be expected to handle the chronically ill aged patient who requires coordinated and specialized medical supervision. At present the facilities of most of the homes are strained to the breaking point by an influx of sick persons. These homes are consequently being forced into a program of medical care with facilities and staffs which are inadequate for the job at hand. This type of patient should be treated in a chronic hospital until their condition would permit their transfer into a home for the aged.

It has been pointed out in recent surveys of indigent persons that the greatest proportion of them were forced into the status of paupers by the occurrence of a long illness, the expense of which proved to be catastrophic to their economic status. I have no intention of entering into the controversy over the various types of medical care. However, one cannot escape the fact that adequately equipped hospitals for chronics must necessarily be financed with governmental funds. This need not and should not deprive the solvent chronically ill taxpayer of the benefits of chronic care. It is planned that the facilities of the future Cuyahoga County Chronic Hospital be available to chronically ill patients who are able to pay. In this manner private patients will be accorded the advantages which only a specialized institution has to offer them.

NEED OF RESEARCH

It is known that many of the chronic diseases are still a virginal field for medical research and will remain so until the chronically ill patient is able to receive the high grade medical service offered by the general hospital. What fruitful results might have been obtained by the application of modern research techniques to the diseases of the chronic—arthritis, multiple sclerosis, cardiovascular disease, cancer, etc., can be estimated by reference to the many developments that burgeoned in a relatively few months during World War II.

The question arises: What types of care other than the chronic hospital are required for the chronically disabled individual? The care of such patients obviously begins in the home with the onset of the illness. Usually he is treated by a private doctor as long as he remains solvent. Then the public agencies which include the social worker, the visiting nurse and/or a visiting housekeeper enter the picture. The only medical care available is provided at last in the larger communities by the city physician who is usually overburdened so that the time allotted the sick patient is much too brief for satisfactory diagnosis and treatment, or in the outpatient department of a general hospital if one is available. At any rate the intensive medical care which is often necessary at this stage of the

illness is not always forthcoming. To my mind this constitutes the gravest defect in the ideal management of chronically ill patients. This lack is usually recognized by the family as well and they start a campaign to place the patient under more adequate care. I firmly believe that if appropriate medical services, i.e., hospital care in the vast majority of instances, were provided early, a large number of patients who later become hopelessly disabled would be rehabilitated.

Foster homes for the care of the chronically ill serve a useful function, being suitable for patients in whom though complete recovery is impossible still do not require continuous treatment in a chronic hospital. Obviously such patients can largely care for themselves and may even participate in some of the household duties. It follows that any prescribed treatment such as medication or insulin injection which may be necessary can be given here under trained supervision. Should the need arise for more intensive treatment the patient would qualify for readmission to the chronic hospital.

BOARDING HOMES

There is another category of patients who require not only provision for their meals but also assistance with dressing, bathing, and making their beds. This type of service may be met by a so-called "boarding home." Unfortunately many of these homes are poorly supervised, are fire hazards, overcrowded, and fail to meet even minimum standards of sanitation. These homes are frequently operated solely for profit with little regard for the patient.

The boarding home could well serve as a useful link in the chain of chronic care. What is the actual situation at present for chronically ill persons? The patients who are inmates in the average boarding home are neglected to an extent that medical attention is supplied, if at all, only after they have broken down when any chance of rehabilitation or return to their previous physical state is entirely lost. A partial solution might be found were the old age pensions available to defray the costs of medical care in the chronic hospital. The grants are frequently insufficient to meet all the requirements of the well person, and certainly inadequate to provide medical and nursing care. I have seen a totally disabled individual voluntarily leave the Nursing Home so that he might be eligible for his Old Age pension. Consigning such patients to boarding homes is tantamount to signing death certificates. The destitute are infinitely better off. A more logical solution would be: First, to increase the allowance to the chronically ill so that the boarding homes could employ adequately trained nursing help; secondly, adequate supervision and inspection of the boarding homes by state license; thirdly, to

establish a continuous liaison with a chronic hospital.

What of existing chronic hospitals? It is known that many of the metropolitan centers in the United States have provided facilities for the chronically ill. In many localities the county government is charged with the care of the permanently and totally disabled indigent. Often these patients are treated on a so-called hospital ward which is part of an infirmary or poor farm. These institutions frequently are situated many miles from a town so that the patients may receive "sunshine, fresh air, and nice scenery," which in my opinion is not nearly so important as a centrally placed institution. Many patients prefer to forego hospital care in order to remain in the city where they have spent their lives. They want to be situated near the familiar haunts even though they may be unable to get out to see them and where relatives and friends can conveniently visit them. This is precluded by a distant hospital. A central location in the city is also within easy reach of attendants, nurses, doctors, and medical students. This important fact must not be minimized. The facilities of a chronic hospital should be particularly geared in providing diagnosis and treatment of those conditions for which no provision is made in the acute hospitals such as multiple sclerosis and arthritis. In this respect the physical medicine department should in fact serve as an important cog. The type of therapy and its objectives are not to be compared with the counterpart in a general hospital.

At the Nursing Home there is a dental department with facilities for X-ray, extractions, fillings, bridgework, and even dentures. Bed-ridden patients should not be denied dental care and accordingly a mobile unit is available. Most important is the provision at the bedside for prophylaxis and fillings.

SUMMARY

The chief aim of this discussion of the chronically ill has been to emphasize the real and urgent necessity for chronic hospital care. An attempt has been made to show the roles played by the general hospital, home for the aged, the foster home, and the boarding home for disabled persons of all ages. It is our hope that in the not too far distant future these facilities will be available to persons of all social and financial levels who are in such great need of the specialized services offered by chronic hospitals.

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Antibiotics in Ear, Nose, and Throat

In the first place, I am inclined to be conservative insofar as the routine use of these drugs is concerned. I do not believe it is necessary or advisable to give a sulfonamide drug or penicillin in the average case of acute sinusitis or sore throat, since most of the patients recover spontaneously under conservative palliative measures. Why expose the patient to the possible reactions ensuing from the use of the drugs or the danger of rendering his flora resistant? My only exceptions to this rule are cases accompanied by more than average rise of temperature or when there is a possibility of impending complications.

As for the local use of antibiotics, I have not found much advantage in the use of powders, sprays, or inhalations in the average acute nose and throat infection. Besides, it is inconceivable that the brief contact of the drug with the surface can accomplish any more than the neutralization of the surface bacteria. Experiments have shown that bacteria residing in the deeper recesses can be reached only through the circulation.

As for acute otitis media, it is difficult to withhold penicillin, particularly in children, because of the attitude of the parents as well as the pediatrician. The publicity which this drug has received seems to have convinced the public of its infallibility, and it is almost foolhardy for the otologist to resist. Nevertheless, I am convinced of the value of the drug provided it is intelligently administered and controlled. What I object to is the total reliance on the drug to the exclusion of other factors. We must never lose sight of the fact that fundamental surgical principles still hold good. Pus must be evacuated and necrotic tissues removed.

My feeling with regard to this whole subject may be summed up in this way: Antibiotics are extremely valuable ammunition which, when properly employed, can overcome hitherto resistant and often fatal infections. They should be employed only when strictly indicated and in sufficient amounts according to the severity of the infection and the bacteria involved. They should not be used routinely in minor self-limited infections or in chronic infections to the exclusion of other well founded therapeutic principles.—Samuel Salinger, M. D., Chicago; *Wisc. Med. Jrn.*, Vol. 47, No. 10, Oct., 1948.

Gynecology in the Elderly Patient

RALPH W. EDDY, M. D.

It is difficult to present a comprehensive subject such as geriatric gynecology in any limited space. Obviously, it includes all gynecological conditions which are found in the elderly patient and it becomes immediately evident that all conditions are found except those relating to menstruation or pregnancy. Of course, the incidence of various diagnoses differs greatly from that seen in the childbearing age and that of the pediatric age. We would expect, for example, to find a very high incidence of relaxations of the pelvic floor because of the tendency to loss of tone and elasticity following menopause. We would also expect a relatively high incidence of malignancies because of the generally increased number of such tumors in elderly people. On the other hand infection of the genital organs, particularly of the upper genital tract, are relatively infrequent as most of these are secondary to coitus or abortion.

It is apparent that establishment of the diagnosis in the geriatric patient usually presents no great problem except in those with adnexal tumors or bleeding from the uterus. Relaxations are easily determined by the usual bimanual and speculum examinations; cervical lesions are easily biopsied; and lower genital tract infections are usually classified without difficulty.

It is in the matter of management that these patients are more difficult. Uterine bleeding of any type occurring several to many years after the menopause is always dangerous until proved otherwise. This usually requires a curettage to establish the diagnosis and perhaps a hysterectomy to correct it. Relaxations of the supporting structures have long been treated with varying success with numerous types of pessaries. While these devices have important advantages in many cases, they have serious disadvantages, and very few afford the complete relief that a good reconstructive operation yields. Other patients present themselves with large adnexal or uterine masses, demanding laparotomy for cure.

It is the matter of operative procedures requiring some type of anesthesia that too frequently terrifies the patient. How many times have we heard "Oh, but doctor, I am too old to have an operation!" or "My doctor told me I couldn't undergo surgery." Unfortunately, many elderly patients pass up valuable symptomatic relief and even life-saving procedures because of this attitude for which, I believe, the profession is largely responsible.

Presented before the Section on Obstetrics and Gynecology at the 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, March 30, 1948.

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It is well to remember that most elderly patients have reached their age because they are inherently of good protoplasm. With the help of good laboratories, good internists, and competent anesthetists we are now able to prepare most patients adequately and carry them through the operative and postoperative periods with relative safety. With the exception of phlebitis and pulmonary embolism and perhaps postoperative psychopathies, I believe the risk is not materially greater than in the usual age group of our patients.

I should like to present the results of a study of 224 private patients who were 60 or more years of age when they were first seen by me. These patients occurred in a series of 5,472 consecutive private gynecological patients, an incidence of 4.1 per cent of the total. Patients were not included who were less than 60 years of age when they were first seen, even though some of them were 60 or more when they were operated upon. Older gynecologists almost surely have a higher ratio of patients beyond 60 because patients seem to prefer a physician near their own age.

Table I

Total Gynecological patients.....	5,473
Patients 60 years of age or older.....	224
(4.1% of total)	
60 through 64.....	100
65 through 69.....	71
70 through 74.....	34
75 through 79.....	11
80 and over.....	8

Diagnoses given are clinical diagnoses except in operative cases where tissue was obtained in which cases the pathologist's diagnosis is recorded.

As expected, the incidence of relaxations of the various types was high. In fact, it was con-

siderably higher than anticipated. Almost 60 per cent of the total had some type of relaxation though a few were apparently asymptomatic. It was interesting to find that seven out of 43 nullipara had very real relaxations, three of them with third degree prolapses of the uterus. The diagnosis of enterocele was included when there was an appreciable bulge posterior to and below the cervix on straining. In a fourth or more of the 46 recorded, the sac apparently descended to the introitus or below. The incidence of prolapse of the uterus is correspondingly high. I believe that most of these are associated with enterocele. Prolapse of the cervical stump after supravaginal hysterectomy is likewise associated with enterocele.

Table II

Principal Diagnoses:	
1. R.P.F. with rectocele and/or cystocele	130
2. Enterocele	46
3. Prolapse of uterus or cervical stump	61
1°-34; 2°-14; 3°-13	
4. Kraurosis Vulvae	4
5. Carcinoma of vulva	2
6. Urethral caruncle	22
7. Ulceration of vaginal wall (pessaries)	6
8. Carcinoma of vagina	2
9. Vaginitis (Various types)	12
10. 3° perineal laceration	2
11. Chronic non-specific cervicitis	41
12. Cervical polypi	17
13. Carcinoma of cervix	12
14. Fibromyomata uteri	14
15. Carcinoma of body of uterus	11
16. Bleeding from estrogenic therapy	7
17. Bleeding from undetermined cause	5
18. Endometrial polypi	6
19. Sarcoma of uterus	1
20. Ovarian tumors (not operated upon)	5
21. Pseudomucinous cystadenoma of ovary	4
22. Serous cystadenoma of ovary	2
23. Type not determined—torsion & necrosis	2
24. Brenner cell tumor of ovary	1
25. Carcinoma of ovary	1
26. Sarcoma of ovary	1

Carcinoma of the vagina was seen twice. One was primary, not associated with the wearing of a pessary. The other was secondary to adenocarcinoma of the body of the uterus and was implanted on an ulceration due to a donut pessary. There were five other ulcerations of the vagina from ill fitting or neglected pessaries.

Carcinoma of the cervix occurred 12 times. Two were carcinoma in situ discovered by the pathologist after operation. Four, all moderately or far advanced, occurred in the group of 43 nullipara.

Carcinoma of the body of the uterus was proved

in eleven patients. Two of these were in the group of nullipara. Uterine bleeding due to estrogens was fairly well proved in seven cases. Five others with uterine bleeding did not have curettage and the source of the bleeding was not determined. Endometrial polypi were demonstrated in six. Not all of these produced bleeding according to the patient.

Sixteen patients had adnexal masses interpreted as tumors. Five were relatively small and operation was not advised or was refused. Of the eleven operated upon eight were very large tumors weighing up to 45 pounds. Type was not determined in two who had necrosis of the tumor from torsion of the pedicle. Interestingly enough, six of the large tumors occurred in the group of 43 nullipara. The patient with sarcoma of the ovary had been treated eight years previously with radium and X-ray for carcinoma of the body of the uterus which was still present at operation.

In all, there were 36 patients with malignancies, 30 of these occurred in the pelvic organs.

Table III

Other Diagnoses	
Normal post-menopausal organs	25
Carcinoma of colon	3
Carcinoma of bladder	1
Carcinoma of breast	2
Summary of Malignancies	
Of pelvic organs	30
Other than pelvic organs	6

There were 64 major operations in this group: they are listed as indicated according to the principal procedure. Repair of the enterocele was done in all vaginal hysterectomies and in several of the Fothergill operations. One operation was excision of a cervical stump and repair of enterocele.

Table IV

Major Operations - 64	
1. Fothergill operation with perineorrhaphy	22
2. Abdominal panhysterectomy	15
3. Vaginal hysterectomy with perineorrhaphy	11
4. Perineorrhaphy and/or anterior colporrhaphy	6
5. Modified Le Fort	4
6. Vulvectomy	3
7. Salpingo-oophorectomy	2
8. Excision of cervical stump and repair of enterocele	1

There were 27 minor operations as noted in the table.

Table V

Minor Operations - 27	
1. D & C, D & C and excision of polypi, and D & C and cauterization of cervix	15
2. D & C and Radium or Biopsy and Radium	7
3. Biopsy of cervix alone	3
4. Abdominal paracentesis	2

In the group of 133 non-operative cases the disposition was as indicated in the table. Of these, one, a Fothergill repair, has since been done and two others are scheduled for operation.

Table VI

Non-Operative Cases - 133	
1. Operation advised and not done	21
2. Operation advised and referred to other surgeons	5
3. Local or medical treatment	50
4. No treatment recommended or observation only	40
5. Referred to other physicians for diagnosis and treatment	17

The results of operative treatment were quite gratifying. Only one death can be attributed to operation. This patient had a fatal pulmonary embolus on the sixth postoperative day after abdominal panhysterectomy. She had had a large ovarian cyst with torsion and necrosis and innumerable intestinal adhesions.

Table VII

Results in Operative Cases	
1. Small recurrent enterocele	1
2. Died after biopsy of cervix - ca. of cervix	1
3. Paralytic ileus - recovered	1
4. Thrombophlebitis	4
5. Pulmonary embolus - (not fatal)	1
Pulmonary embolus (fatal)	1
6. Wound infection - healed	1
7. Pelvic cellulitis (after vaginal hysterectomy)	1
8. Intestinal obstruction - requiring laparotomy	1

Thrombophlebitis was demonstrated in only four patients though others may have had relatively asymptomatic ones.

One patient was admitted to the hospital with uremia which was found to be due to an otherwise asymptomatic carcinoma of the cervix. This patient had biopsy under local anesthesia only. She was started on X-ray therapy but died of uremia secondary to ureteral compression.

Many patients had cystitis and some probably had pyelitis. This was to be expected because of the large number of patients with cystocele and residual urines. All major vaginal repairs

were treated with indwelling catheters for varying lengths of time, which probably predispose to bladder infections.

In conclusion, it appears from this study of a small series of cases that the elderly gynecological patient frequently requires surgical procedures for relief. If these patients are studied and prepared adequately it seems that a favorable outcome is predictable in most instances.

KEEPING UP WITH MEDICINE

- OCCUPATIONAL therapy was first recommended for mental patients by Asclepiades.

* * *

- AN unusually high percentage of patients with allergies give positive skin tests to fungi.

* * *

- A PERSON in good mental health has a restful face and a happy expression.

* * *

- CONDITIONS as congenial as possible, sufficient nourishing food at as nearly an optimal level as possible, adequate rest, and sufficient open-air exercise are all essential for perfect health. The suggestion, however, is made that sound mental hygiene greatly helps a person seek out such healthful conditions for himself.

* * *

- NEARLY all the conditions encountered in surgery in infants and children differ from those met in adults due to developmental anomalies.

* * *

- RECENT investigations tend to confirm the suspicion that the imperfectly purified penicillin of early days was more effective than the refined present-day product.

* * *

- IN obese persons thyroid hormones should be given solely for the correction of a definite hypothyroidism with the B. M. R. calculated on the average weight for height and not present weight.

* * *

- IN the Middle West during the fifteen-year period, 1929-1944, 7,348 cases of amebiasis were reported in Illinois, 476 in Michigan, 793 in Minnesota, and 2,686 in Missouri.

* * *

- X-RAY is responsible for making a correct diagnosis in almost 90 per cent of cases of bronchogenic carcinoma.

* * *

- THE routine physical checkup is incomplete unless there is an examination of the mouth, including the teeth.

* * *

- IN 1944 and 1945, 30 per cent of maternal deaths were due to hemorrhages.—J. F.

The Metabolic Rate in Practice

C. I. REED, Ph. D.

DURING the past thirty years the so-called "basal metabolic rate" test has become standardized and stereotyped in office practice until some of its usefulness has been lost. This first became apparent from responses of medical students who had served as technicians in clinical laboratories to statements made in the course of routine instruction in physiology.

It has been the author's custom to urge upon medical students more accurate technic, thereby narrowing the zone of deviation and improving the statistical significance of small deviations. It is his contention that practical usefulness of the greatest significance is seldom accomplished in this test and cannot be attained until the allowable deviation is greatly reduced. Stated differently, even very small changes have physiological significance if one has provided correlations between these changes and clinical states upon which to base interpretations.

Most clinical metabolists allow a range of -10 or -15 per cent to $+15$ per cent. This means that figures falling within a zone of 25 to 30 per cent are discarded as of no diagnostic significance. From the viewpoint of a physiologist, this attitude is not supported by experimental data. In the author's experience daily inter-individual deviations for human subjects have been reduced to ± 3.8 per cent and for intra-individual deviation to ± 1.7 per cent. Assuming a standard of $40 \text{ K Cal/M}^2/\text{hr.}$, this would mean a deviation of 1.52 K Cal among individuals and 0.68 K Cal between tests on the same individuals. Even among well-trained dogs, it is possible to reduce intra-individual deviations to ± 5 per cent. The inter-individual deviations among dogs are, of course, likely to be much greater because of the greater variety in surface contour which complicates calculation of surface area.

SERVED AS SUBJECT

This paper reports observations of an experienced metabolist who had also served as a subject many times and whose metabolic history was well known, who visited, incognito, 17 metabolic laboratories within a radius of 200 miles of the Chicago Loop and by various means, succeeded in securing reports of tests done on himself. During the past 10 years this subject's metabolic rate has ranged between 35.8 and $39.7 \text{ K Cal/m}^2/\text{hr.}$ with a mean of 37.6. Several other laboratories were visited but it was im-

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possible to get the data reported in a form suitable for comparison.

Table 1 shows the data as actually reported to the subject, or in a few instances, to a physician who had agreed to participate in the experiment.

Table 1

$\text{K Cal/m}^2/\text{hr.}$ Data obtained in tests on a healthy, normal subject in different laboratories.

$\text{K Cal M}^2/\text{hr}$			
1	59	10	*39
2	52	11	*39
3	52	12	*39
4	46	13	36
5	44	14	33
6	43	15	30
7	42	16	30
8	42	17	27
9	40		

* According to the subject's observation, these laboratories displayed the most satisfactory technic.

In both of the laboratories giving the extreme figures, definite mechanical faults were detected in the equipment. A second visit to one of them a week later revealed that these faults had not been corrected. In both instances, many other additional factors of error were detected.

In Table 2 are listed the factors which the subject was able to observe which seemed to be responsible for some of the discrepancies.

It is apparent from Table 1 that if these data are representative of what may be expected from metabolic laboratories in general, the use of the test for diagnostic purposes should be discontinued because, by every criterion, the results are wholly unreliable. It should be mentioned that the subject, in every instance, went back to his own laboratory the following day and had a very careful test made, which in only five instances checked reasonably well with the corresponding test as reported in Table 1.

From Table 2 it is apparent that the most important factors of error are due, either to carelessness or to ignorance of the nature of the test. Unfortunately, when the test was first introduced thirty years ago, physicians in

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general had little training that would enable them to interpret the data. In an effort to aid the busy physician who did not understand, researchers, teachers, and manufacturers entered, perhaps unwittingly, into an unholy alliance in an effort to simplify the test to a degree that would relieve the physician of the necessity of knowing anything about it. Tables

Table 2

Type of fault	Number of times observed
1. Lack of understanding of principles	9
2. Incorrect methods of calculation, too many short cuts	7
3. Faulty checking of equipment	7
4. Failure to correct for vapor tension	4
5. Inaccurate ruling of graph	3
6. Mechanical faults	2
7. Inferior instrument	1
8. Disturbance of subject by observer talking in room	3
9. Room too warm	2
10. Room too cold	3
11. Bed uncomfortable	2
12. Conduit fouled so that subject became nauseated	1
13. Error in reading thermometer in oxygen chamber	1
14. Inexperience of operator, no supervision	1

and nomograms were constructed—ingenious developments of themselves—which would enable the operator of metabolism equipment to measure a graph then read off from a table or nomogram the result.

STANDARDS VARIED

In the state of knowledge a quarter of a century ago perhaps it was true that a basal metabolic rate within the ± 25 per cent zone was of no significance, diagnostically. But the situation which developed was analogous to that relating to hemoglobin determinations in blood samples. It will be recalled that there were in use only a few years ago five different hemoglobinometers each with a different standard in terms of grams of hemoglobin per 100 cc. of blood but all reporting in terms of percentage of an arbitrarily adopted “normal” standard. Clinical records, however, seldom recorded the method but only the percentage which may have been based on a standard varying from 12.5 to 17 grams per 100 cc.

After thirty-six years as an instructor in various capacities in medical schools, the author contends that the medical student is certainly intelligent enough to merit instruction in facts rather than elided short-cuts in simple calculations. At least, there is no evidence that physicians are confused by reporting hemoglobin in terms of grams per 100 cc. rather than in percentage. They have had no difficulty understanding or interpreting the figures for calcium, phosphorus, sugar or protein in the blood. By the same token there is no sense in teaching students to report metabolic rates in percentages of some one of three or four standards when

recording in terms of calories per square meter per hour will give a much more accurate picture of the patient's state and will eliminate all necessity for reference to tables except for purposes of occasional verification.

Trials with children 12 to 15 years of age who were given empirical instruction in making the calculations from the DuBois formula have shown that anyone can learn to make these complete calculations accurately and quickly with no elisions. Similar trials with medical students have shown that the various short cuts used in practice do not materially reduce the time required. Students made the complete calculation within periods only about 15 per cent greater than that required to read off the data from a table and the accuracy of the data was very much greater.

TERM “STANDARD” PREFERABLE

Another point which might be worthy of consideration is the designation “basal metabolic rate.” Actually, it is almost never basal because the imposition of further conditions will reduce the rate, as determined, still further. In actual practice the figure is obtained under a certain set of arbitrarily standardized conditions which may be made more rigid by adding to the requirements for standardizing. Consequently, it would appear to be preferable to designate it as Standard Metabolic Rate (SMR) rather than Basal Metabolic Rate (BMR). The implications of the test might be a little less confusing. This suggestion has been voiced by many workers in this field during the past ten years.

SUMMARY

In summary, then, it would appear to be desirable to (a) increase the accuracy of the test so that minor variations may have diagnostic significance; (b) report results in K Cal/M²/hr., rather than in percentage; (c) calculate the results in full rather than by short cuts; and (d) adopt “standard metabolic rate” instead of “basal metabolic rate.”

The Use of Testosterone

Testosterone is useful in uterine bleeding when all other means fail. I have yet to see a patient with functional uterine bleeding in whom the administration of 25 milligrams of testosterone every other day or every day for a period of three or four days would not eventually control the bleeding. It is of some help as a temporary measure in the treatment of dysmenorrhea. With it one may be able to suppress ovulation and control dysmenorrhea. Similarly it may be of some use in the treatment of endometriosis.—Joseph A. Hardy, M.D., St. Louis; The Jrn. of the Missouri State Medical Association, Vol. 45, No. 11, November, 1948.

Tonsillectomy and Poliomyelitis in Cuyahoga County, Ohio

CHARLES E. KINNEY, M. D.

A FEW years ago, it was suggested that the removal of tonsils and adenoids in a child when poliomyelitis was in that community multiplied that child's chances of getting polio particularly the more serious or bulbar type. This started a wave of public hysteria that spread to unhealthy proportions. Two extreme instances are worth mentioning. It has been written that any child who has had his tonsils or adenoids removed is more susceptible to polio inferring that this susceptibility extends for many years. Nothing could be further from the truth. Recently an adult in our city died of pneumonia as an indirect result of a bulbar polio that this person had acquired three months previously. When it was announced in the papers that a public funeral was being held, the health department of that city was deluged with protesting telephone calls.

It was this condition that instigated the survey to be reported in this paper. The American Laryngological, Rhinological and Otolological Society has been sponsoring an annual survey of this problem. This survey has been under the supervision of Dr. D. S. Cunningham,¹ with the assistance of otolaryngologists in practically every state. For the year 1946, he reported a survey of 5,872 cases of poliomyelitis in the United States which was 23 per cent of all cases reported. Of this number, 91 cases (1.6 per cent) followed recent removal of tonsils. In order to further study the mathematical probabilities of this assumed relationship I have introduced two additional factors, namely, the 4 to 19 year population of a given community and the number of tonsils and adenoid operations performed in that community.

This survey was done for the years 1946 and 1947 in Cuyahoga County, Ohio, which has a total population of about 1.4 million or one per cent of the total U. S. population. A study of the monthly polio figures in Cuyahoga County during the past 20 years shows that they follow the national figures quite closely. I would like at this time to thank the executive officer of every one of the 20 hospitals in Cuyahoga County who are members of The American Hospital Association and in whose institutions tonsil and adenoid operations are performed, as this survey would have been impossible without their cooperation. I wish also to thank Dr. J. G. Smith of the Cleveland Health Department

¹Presented before the Section on Eye, Ear, Nose, and Throat at the 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, March 31, 1948.

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for his assistance in obtaining the quoted vital statistics.

For purposes of comparison, I have confined all of my figures to the ages of 4 years to 19 years inclusive. The population figures were arrived at from the birth figures of the years 1927 to 1943. From a study of the estimated total population during those years it is fair to assume that deaths and removal from the county would be balanced by new children being moved into this county. The numbers of tonsil and adenoid operations is minimal because there was no way to obtain figures from hospitals not associated with the American Association or private offices where this operation is performed.

In Table I, I have tabulated the number of tonsil and adenoid operations and the number of

Table I

Residents Cuyahoga County, Ohio, Ages 4 to 19 Yrs.				
	1946		1947	
	Total 298,475		302,633	
	T & A	Polio	T & A	Polio
Jan.	431	0	691	0
Feb.	421	0	631	0
Mar.	765	0	652	0
April	980	0	1064	0
May	1415	1	1272	0
June	1123	5	2271	1
July	760	46	929	6
Aug.	429	68	556	18
Sept.	322	70	694	81
Oct.	946	30	1179	55
Nov.	1271	12	1151	22
Dec.	1004	5	1323	1
Totals	9873	237	12413	184

polio cases by months. As to the operations, you will notice in both years that there was an increasing curve starting in April and reaching a peak about the middle of June and then there is a sudden slackening off with a low point around the end of August. The polio cases during both years peaked in the month of Sep-

tember. You will notice that we had polio in Cuyahoga County from June to December inclusive during both years and in 1946 there was one resident case in May.

During 1946, there were four polio cases that had a tonsil operation performed within 60 days previous to the onset of their polio. Those cases were as follows:

Female, 7 years, tonsillectomy July 2, 1946—
Onset polio July 17, 1946

Female, 7 years, tonsillectomy July 16, 1946
—Onset polio July 31, 1946

Male, 9 years, tonsillectomy July 28, 1946—
Onset polio August 30, 1946

Female, 4 years, tonsillectomy September 9, 1946—Onset polio September 20, 1946

In 1947 there was only one such case as follows:

Female, 10 years, tonsillectomy August 25, 1947—Onset polio September 8, 1947

Of these five cases there was only one that was of the bulbar type and it was a mild case.

For the analysis of these cases, I am indebted to Dr. Rafael Dominguez, Cleveland, Ohio. As well as a nationally known pathologist, Dr. Dominguez is a well-known mathematician. In view of the fact that the method of transmission of the polio virus is as yet unknown, he felt that the fairest way to evaluate these figures was to include those months in which there were proven cases of polio in the community. In Table II, he has tabulated these figures for 1946 according to the accepted way of calculating expectancies.

Table II

Analysis 1946 Cases				
		Polio Months May to Dec. Incl.		Total
		Polio	No Polio	
T & A	Expected	5.77	7266	7270
	Actual	4		
No T & A		233	290972	291205
Total		237	298238	298475

In the first vertical column, there is listed the polio cases that had a tonsillectomy and adenoidectomy numbering four and the polio cases that did not have a tonsillectomy and adenoidectomy numbering 233 with a total of 237. In the second column, there is a number of tonsillectomy and adenoidectomy cases that did not develop polio numbering 7,266 and the number of non polio cases that did not have a tonsillectomy and adenoidectomy numbering 290,972 with a total of 298,238. In the third column, there is the total tonsillectomy and adenoidectomy cases during the polio months numbering 7,270 and the total non tonsillectomy and adenoidectomy cases numbering 291,205 with the total 4 to 19 year population of 298,475.

By using the following formula he has calculated the expectancy of tonsillectomy and adenoidectomy polio cases: the expected cases

should be to the total polio cases (237) as the total tonsillectomy and adenoidectomy cases (7270) is to the total child population (298,475). The answer is 5.77 or 1.77 more than the actual tonsillectomy and adenoidectomy polio cases. In Table III, the same method of tabulating

Table III

Analysis 1947 Cases				
		Polio Months June to Dec. Incl.		Total
		Polio	No Polio	
T & A	Expected	4.93		
	Actual	1	8102	8103
No T & A		183	294347	294530
Total		184	302449	302633

and calculating the figures for 1947 has been followed. Here you will see that the normal expectancy was 4.93 while the actual number of tonsillectomy and adenoidectomy polio cases was only one or 3.93 less than the normal expectancy.

For the benefit of those who would contend that we should have used only the months during which polio could be considered as epidemic, the same formula has been applied. During 1946, those months were July, August, September, and October. During 1947 those months were August, September, October, and November. By this method the expectancy for 1946 is 1.76 or about one half the actual number. However, in 1947 the expectancy is 2.08 or approximately twice the actual number.

SUMMARY

1. For both 1946 and 1947 in Cuyahoga County, Ohio, the number of children who developed polio after having had their tonsils and adenoids removed was less than the normal expectancy.

2. It would seem that the relationship between this operation and the acquiring of polio is no more than casual and the public hysteria concerning this problem is unwarranted.

3. As was done during 1946 and 1947 in Cuyahoga County, Ohio, the concentration of anticipated tonsillectomy and adenoidectomy cases during the months of April, May, and June seems to be a satisfactory method of handling this problem.

4. A new method for studying this problem has been presented.

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The nitrogen mustards have been shown to arrest the course of Hodgkin's disease in the majority of cases, but the change is temporary. In general, patients with Hodgkin's disease who have had no previous therapy have responded better and for longer remissions than those who have had X-ray therapy and are no longer responding favorably.

Nutritional Problems in Surgical Patients with Special Reference to Depletion of Plasma Protein Reserves

FREDERICK R. MAUTZ, M. D.

DURING the past decade a new surgery has emerged—physiological surgery. This was the logical sequence of developments in the fields of physiology and physiological chemistry in the preceding decade. In surgery of today there has been a considerable shift from the purely anatomical and pathological considerations in the removal of diseased tissues and organs to a more careful integration with the vital body functions of whatever operative procedure is contemplated, so as to at all times minimize the deviation from the normal in the preoperative, operative, and postoperative periods.

PREOPERATIVE WEIGHT LOSS AS A FACTOR INCREASING OPERATIVE RISK

I believe I can best discuss the subject by reviewing some of our experiences on the surgical service of the University Hospitals of Cleveland during this last decade as they were related to the revolutionary developments in this field. Antedating our present concept of the role of malnutrition in surgical patients was the study of Hiram O. Studley,¹ published in 1936. He attempted to find out what factors are of greatest importance in determining the favorable or unfavorable postoperative course in patients with chronic peptic ulcer, on the Staff Surgical Service of University Hospitals, who were subjected to elective gastric resection. This study showed clearly that one and only one factor was of unquestionable significance in this series—the percentage of body weight lost prior to operation. Practically all serious complications occurred in patients who had lost 20 per cent or more of their body weight prior to being operated upon. Technical surgical skill is necessary but not sufficient to be productive of the best possible results.

THE ROLE OF PLASMA PROTEIN DEPLETION

The practical implications of Studley's study were obvious, but the mechanism by which weight loss predisposes to surgical complications was as yet to be determined. G. H. Whipple and co-workers² at the University of Rochester Medical School were studying plasma protein regeneration in dogs made hypoproteinemic by the process of plasmapheresis and provided important data on the problem of nutrition in surgical patients. It was later observed that the hypoproteinemic dogs were unable to heal wounds in a normal fashion, were more susceptible to surgical shock and infections, and in general behaved

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much like the malnourished patients in Studley's series. Following these unmistakable clues, a tremendous literature has developed confirming and amplifying the early findings.

The Rochester group demonstrated that in the well-nourished person there is a limited physiological reserve store of proteins capable of replacing plasma protein that might be lost in hemorrhage or exudate. These stores are not great and consist of approximately two to three times the normal circulating plasma proteins in the well-nourished subject, and when depleted cannot be replaced by remaining body protein as muscle, etc., even when artificial necrosis of body muscle is produced experimentally. It was convincingly demonstrated that when the plasma protein reserves are depleted the only possible means of replacement is from extraneous sources as (1) complete proteins or complete amino acid mixtures ingested via the gastro-intestinal tract; (2) amino acid mixtures given intravenously as originally proposed and demonstrated by Elman;³ or (3) preformed homologous blood plasma. Along with plasma protein depletion, there is depletion of other proteins and, in the process of restoring these proteins, for every gram of plasma protein regenerated approximately 30 grams of other body proteins are formed. It has been amply demonstrated that nitrogen equilibrium can be maintained using either amino acid mixtures or blood plasma administered intravenously as the sole source of nitrogen, at least in individuals in whom there is no great abnormal nitrogen loss.

THE PREOPERATIVE CORRECTION OF PROTEIN DEPLETION

Our initial approach to the problem was to increase the quantity of protein in the preoperative diets, increase the duration of the preoperative preparation, and check more carefully on the exact intake by the patients of protein, carbo-

¹Presented before the Section on Surgery at the 1948 Annual Meeting of the Ohio State Medical Association at Cincinnati, April 1, 1948.

hydrates, and calories, while carefully following plasma protein levels. We made an attempt to apply the data regarding the potency of various food proteins in our clinical cases of protein depletion. In view of the fact that a number of independent assays demonstrated that beef serum protein was far superior to other protein foods for producing plasma protein regeneration in dogs, we used beef serum as a protein food in some of our protein depleted patients. This was administered as a tube feeding into the stomach and in some instances of esophageal or pyloric stenosis was given via jejunostomy tube. However, following the general availability and proven efficacy of protein digests, we have largely turned to these preparations administered parenterally when oral intake is inadequate. Protein digests have been found of value in combination with glucose as a tube feeding for jejunal administration. Where the pyloro-duodenal mechanism is eliminated as a control of the admission of food to the small intestine, serious problems of motility and absorption greatly limit the effectiveness of jejunal alimentation. It is here that the slow administration of glucose and amino acid mixture in concentrations that are not greatly hypertonic seem to find greatest usefulness as a food. Although our ultimate experiences with jejunostomy seemed adequate in every way from a physiological point of view in these patients with inadequate oral intake, this method of feeding was largely given up when we felt certain of the effectiveness of parenterally administered amino acid mixtures. The latter method has gained wide acceptance because of the greater simplicity, but there is much to be said for jejunal alimentation from a theoretical point of view, and there will yet be instances where this method should be used.

PLASMA PROTEIN STUDIES

The total albumin fraction of the blood under normal circumstances is seven times as active osmotically as the globulin. (Per gram the albumin is four times as active osmotically, due to the fact that the albumin molecule is smaller.) An important function of the albumin is to maintain the proper distribution between the intravascular and interstitial components of the extracellular fluid. The globulin fraction constitutes the antibodies, iso-agglutinins, etc.

It has been thought that the serum albumin concentration bears a direct relationship to the plasma protein reserves. Certainly this albumin fraction is most significant to follow in surgical patients, since abnormally high globulins occurring in the presence of liver disease, chronic infection, and in such diseases as multiple myeloma. Such a condition may result in normal or high total protein values in the presence

of hypoalbuminemia. Lowering of the serum albumin below 4.0 grams per 100 cc. was considered significant of some degree of protein depletion, but it soon became apparent that a patient on admission to the hospital could have a borderline value for serum albumin and yet behave suspiciously like a protein depleted patient. The hypothesis was put forward that although the plasma protein concentration might be within the range of normal, there could be a reduction in plasma volume and hence in the total circulating proteins in the patient with some depletion of protein reserves. The experiments of Abbott and Mellors⁴ supported this hypothesis, but raised the question that given a total circulating protein figure on a sick patient, what will be the normal standard for comparison? To answer this question an extensive study of total circulating proteins on normal medical students was carried out⁵ with the result that the natural variation of total circulating proteins as related to the body surface area was so great as to make borderline variations from the normal impossible to detect. Furthermore, plasma volume measurements have not as yet proven to be simple, accurate, and reliable enough for general laboratory use. All this again focused our attention on the patient's history and clinical findings. We must consider that any patient who has been progressively losing weight up to the time of admission to the hospital is at least partially depleted of plasma protein reserves.

We did not perform elective major operations on these patients until we were certain they had received a good diet with daily protein intake preferable 100 to 150 grams per day for a considerable time prior to operation. Rules of thumb have been devised by others for the length of time a patient must be so prepared, but it seems there should be a more physiological approach to the problem as to when a patient's reserve plasma proteins have been built up to a point where a major operation can be safely performed. Of course, the ultimate test is the response of the patient to the operation, but this is an "all or none" proposition, and one would like to have a test equally good and less risky as far as the patient is concerned.

We noted consistently that when plasma protein depleted patients were placed on a high protein intake, by whatever route we chose, there was a marked diuresis usually between the fourth and eighth days after the increased protein intake, during which time fluid output exceeded fluid intake. After this, the urinary output again becomes fairly constant, but at a greater and more uniform daily volume than before the addition of the protein to the diet. Following the period of diuresis, the body weight may remain unchanged, but it is obvious that

there has been an exchange in the form of added body substance for the excess extracellular water removed. It should be emphasized that the correction of plasma protein depletion is a rather slow process and to be complete required a considerable length of time—the time being determined by such factors as protein catabolism, protein intake, and hepatic function, all of which are variable factors. Hence the futility of trying to formulate a simple rule for the length of time a patient must be fed based on the percentage weight loss. The aim in a badly depleted patient should be to overcorrect. In the well-nourished patient the brief period of starvation can easily be tolerated without any parenteral protein administration. The protein sparing action of glucose administration should be utilized in these patients in connection with fluid and electrolyte regulation during the period of dysfunction of the gastro-intestinal tract.

However, as far as the gastro-intestinal tract is concerned, it should be remembered that after many, if not all operations there is a temporary functional intestinal obstruction or paralytic ileus. Feeding during this phase is worse than useless, since it causes increasing distention and leads to nausea and vomiting. Nitrogen loss is increased rather than prevented and on occasions a paralytic ileus may even prove fatal. It is my opinion that nothing other than clear fluids should ever be administered immediately postoperatively until there is good propulsion of gas through the gastro-intestinal tract as evidenced by peristalsis that can be heard unaided or with the stethoscope and the free passage of flatus.

In general, patients should not be urged to eat in the early postoperative period unless they are hungry. It would seem desirable to keep them a little hungry. In general, hunger is a sign of well-being in the postoperative patient. Now that we have safe and effective preparations for the parenteral administration of proteins as well as glucose, there is no longer any urgent physiological need for early postoperative feeding.

To have the gastro-intestinal tract relatively empty at the time of operation is important in the prevention of postoperative ileus. Many of the early postoperative abdominal cramps or "gas pains" are probably small intestinal in origin. Enemata generally add to the patient's discomfort at this time, and frequently, when enemas are given, the nurse reports that the patient was unable to expel the fluid—ample proof of the absence of the normal colonic motility.

DIETARY CONSIDERATIONS

We should utilize the gastro-intestinal tract to the limit of its ability in the preoperative preparation of patients. Parenteral feeding should

be complementary to this effort. Although assays of various sources of food protein show qualitative differences in their ability to influence plasma protein regeneration, these differences are not of the greatest consideration in the selection of food. Palatability is a very important factor in getting the patient to ingest an adequate quantity of protein. Highly purified proteins are invariably unpalatable, and this characteristic becomes more marked as hydrolysis reduces them to amino acids. We were impressed with this fact when we were trying to feed beef serum to patients.⁶ It would seem that nature abhors a pure protein food. When we were attempting to make beef serum palatable by the addition of carbohydrates, such as dextromaltose, and flavoring agents, such as chocolate, until maximum palatability was attained we found the composition of the resulting mixture to be approximately 20 per cent protein, 75 per cent carbohydrate, and 5 per cent fat.

A very large protein intake, in excess of 2 grams per kilogram body weight, is not the solution to the protein problem. The simple basic foods, such as milk, eggs, gelatin, lean meat, will provide adequate protein if skillfully presented to the patient. Casein preparations are of value in increasing the protein content of the diet. There is no convincing evidence that predigestion is a significant factor in improving nutrition when foods are administered orally. Tube feeding via gastric tube does not promise great advantages except in unusual instances.

All surgical patients should be placed on a diet high in proteins and vitamins while waiting for admission to the hospital. In the chronically-ill patient much time and effort must be spent in the hospital in preoperative preparation.

Selection of the optimum time for operation is worthy of considerable thought relative to the patient's nitrogen equilibrium, state of fluid, acid-base, and electrolyte balance, adequacy of vitamins, renal, hepatic, and gastro-intestinal function, etc. In contrast to the older query, "Will the heart stand an operation?" we must in fact concern ourselves with almost everything except the heart in the bad risk surgical patient. The heart rarely fails to keep up its end of the bargain if all else is in order.

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Alveolectomy—Its Indications and Technique

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ALVEOLECTOMY is the term applied to an operation in which a part or the whole of the alveolar processes of the mandibles is removed. Absorption of the alveolar processes occurs physiologically when the teeth are lost. Alveolectomy as here used implies the surgeon's assumption of command; and usually for the amputation of pathologically affected bone.

Since the enunciation of the theory of chronic focal infection—sometimes attributed to Rush (1815) but really the product of Weigert (1877), Billings (1900), and Rosenow's (1908) clinico-pathological observations—it has remained a debated question as to whether or not this concept really plays a major part in the explanation of systemic disease. It is our contention that the reason for this lies in the fact that arrest in progressive pathology or "cure" has not always been attained after removal of the causative focus. We hold that this is because this removal was not made completely. Failure to see betterment in the patient after such partial operation has disheartened many practitioners.

In our experience most diagnosticians fall into error because in their search for a seeding focus they look for pus. Commonly, such does not appear in and about infected teeth. In fact, as one looks upon the total of the fields of infection of which the etiology is known, one finds fewer which manifest pus formation than those which exhibit only "scar" formation. Tuberculosis is good example. In acute form (as in a caseating bronchopneumonia) pus may be present; but in more chronic sclerosis types, it is absent. Syphilis and typhoid fevers are other examples of specific infections in which pus is not produced. Why then should one look for a focus yielding pus as cause of migraine, trigeminal neuralgia, spotty types of central nervous system disease, arthritis, bursitis, myositis, and various types of skin disease? They have been as long-standing as many a tuberculous or syphilitic lesion.

In trying to say why physicians and dentists failed to bring relief to their patients after "wholesale extractions," Martin H. Fischer¹—the staunchest international advocate of the etiological significance of focal infection for all the commoner examples of systemic disease—pointed out that such was only half-done surgery. Not only were the teeth but the bone around them infected and in need of removal as had been the teeth themselves. Pathogenic organisms are regularly isolatable from the after-remaining alveolar processes, and this for

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years after loss of the teeth. It is difficult for anyone pathologically trained to see how the mere removal of a tooth in a pyorrheic jaw can by itself rid the patient of an infection already spread into his circum-dental tissues. It is an accepted principle in orthopedic surgery that in the eradication of an area of infection in a bone, all of it must be removed. Surgical attack upon an infected jaw cannot escape this law even though the extractionists have long tried to do so.

In 1776, John Hunter declared the teeth, bones, and the alveolar processes of the jaws not a part of the mandibles but of the teeth themselves. He said that they arose with the teeth in their eruption and fell after their loss. This is the law of tissue development through use; and its atrophy through non-use. The dentists recognize the latter half when they say that they expect the "gums to shrink" after extraction. It is not the gum but the bone underneath it that is absorbed.

It is this regard for the facts that has led us to these dogmatically stated conclusions. (1) The surgeon should remove at once what nature will remove anyway. This means the bony septa between the teeth and the buccal, labial and lingual plates of both jaws. In the more extreme cases, we remove a goodly portion of the hard palate also. (2) All bone should be removed regardless of how extensive the operation, until a level of good blood supply is reached (the rami should not be left as ivory-like structures but should be cut back until they bleed). (3) That which shows either calcium loss (loss of trabeculation) or hypercalcification (increased X-ray density) should be removed.² This is particularly important in the upper jaw wherein original dental infection has spread not only into the alveolar processes but into the bony floor of the antrum and through this into the antrum itself. (4) Remain cognizant of the fact that physical examination is usually superior to anything revealed in X-ray. Tenderness on deep pressure and/or discoloration of the mouth lining over an alveolar ridge, is evidence that the bone underneath is

¹Read before The Indiana Dental Society, April 10, 1948.
²Submitted for publication May 31, 1948.

diseased. It calls for surgical removal even when it extends through the bony floor of the antra.

SURGICAL PROCEDURE

Our patients are instructed to eat well the day before the operation, including a good breakfast the morning of the operation. One-half hour before operation the patient is given from 1-1/2 to 3 grains of seconal. Local injection is made as necessary with procaine and cobefrin. When the anesthetic has taken effect the gingival margin is incised and the periosteum is stripped back. If teeth are present, they are removed in the usual fashion. The bony septa between the teeth are always removed. The alveolar process is removed throughout the operated areas, its edges tapered down according to the technique described by Fischer.³ If good punctate bleeding of the bone is not observed, the operation is extended until such bleeding bone is reached. In operations on the upper jaw this frequently requires the removal of the antral floors.⁴ If the antral mucous membrane is pathologically involved, it is removed through the operative wound, at times in its entirety. Often we put windows into the nares, if the natural ostia are occluded.

Actual removal of bone is accomplished for the most part by the use of rongeurs, after which a bone file is used to smooth off the high points. We object to burrs, as the heat generated by the friction may produce a bone necrosis which may not show up for several weeks after operation. During the operation, bleeding is controlled by pressure only, and the wound is frequently washed with hypertonic saline solution. After all diseased bone has been removed or such as we feel will not adequately be supplied of blood, closure is made with interrupted black cotton or silk sutures. The wound is washed well with hypertonic saline, and sucked and sponged dry to make sure that the bony ridges remaining, exhibit good bleeding. The sutures are usually removed twenty-four hours later and the wound again irrigated with hypertonic salt solution. We aim for healing by granulation and not per primum. When penetration into the antrum has shown it to be clean, here healing is allowed to occur per primum. We wash out accumulates of blood between the lips of the wound or when they occur in the antrum.

In the closure of the operative wound, care is taken to approximate the periosteum as well as the gingival tissue. We make exception in the case of the attachments of the mouth muscles. Here we do not approximate the periosteum, hoping that the muscles will attach themselves at a lower level on the maxilla or the mandible, thus to make the problem of prosthetics easier.

The so-operated usually heal in from two to

four weeks. It needs to be remembered however, that these are operations on bone; that bone repair when clean takes several weeks, and in the face of persistent infection may take months. What is the healing of a clean fracture and/or of a compound is involved. In all these cases we continue with salt-water irrigations and iodine. The patient is allowed to get dentures as soon as healing is complete. In most cases these must be relined after a varying period of time (because, as the dentists say, "the gums shrink").

We do not consider any patient free from oral infection so long as his constitutional symptomatology continues or recurs; or while he continues with abnormal discolorations in his oral mucous membranes or tenderness on moderate pressure under any portion.

CONTRA-INDICATIONS

To our way of thinking, there are no contra-indications to alveolectomy. We have had no anesthetic or operative accidents in a rather large series. We warn constantly against under-operation even in the seriously ill. This goes contrary to the normal trend of thought, as expressed especially by the oral surgeons. The most serious threat to a patient afflicted of systemic disease lies not in doing too much surgery upon him but in doing too little—half-way penetration into an infected bone, "stirs up" the patient. On this account, we refuse to operate even the gravely ill unless permitted to do all that seems necessary.

SUMMARY

1. Alveolectomy requires consideration whenever infection of the teeth is believed etiologic factor in constitutional disease.
2. Alveolar absorption is a physiological process which the surgeon better takes over in states of infection.
3. Alveolectomy is a safe procedure when in surgical terms it is done completely; dangerous, when done partially.
4. It is best accomplished under local anesthesia.
5. Best care for the operated lies in frequent irrigations with hypertonic saline and the light application of tincture of iodine.
6. Because the operated tissues are infected, healing per primum is rarely accomplishable or to be desired. Healing by granulation is best.

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Recent Advances in Plastic Surgery of the Face

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PLASTIC surgery, especially cosmetic plastic surgery, is the most recent of all the surgical specialties. It is so recent, that very few surgeons practice it, and it is an unknown field of knowledge to even the most recent medical school graduates. It has required many centuries, many wars, and much medical curiosity to demonstrate that sculpture of living tissue is possible. Until the modern wars, plastic surgery was practiced almost secretly by a few surgeons. There was a strange feeling that somehow surgical skill was being employed for rather unnecessary purposes when it was used to improve personal appearances. It was considered the work fitted for a Charlatan or an unscrupulous doctor, who did the work in his own office, to please the idle rich who could afford his fees. The procedures were kept secret and the surgeon was not a leading light in his community. When plastic operations were used to correct deformities resulting from trauma received in war, it was seen that a tremendous psychologic improvement accompanied cosmetic improvement, and plastic surgery was adopted guardedly as legitimate surgery.

This last World War with its great number of airplane accidents and explosions of high powered shells, gave many opportunities for men to become experienced in that field. The automobile accident has replaced the high explosives of war as the chief cause of deformities, and the plastic surgeon is required to exercise the same ingenuity and skill to reconstruct and alter the shape of viable tissue after disfiguring automobile accidents as after injury in war. He also remodels hereditary deformities. Personal appearance today is important in the economic scheme of life. Deformities, especially visible deformities, are psychologic handicaps.

HISTORY OF PLASTIC SURGERY

One of the most important procedures in cosmetic and reconstructive plastic surgery has been reconstruction of the nose. The history of plastic surgery of the nose can be taken as the history of all plastic surgery, because the first procedures and all subsequent findings were done on nasal reconstruction. Restorative rhinoplasty was attempted at least one thousand years before the Christian era. The mode of punishment of slaves and of captured foe was the cutting off of the ears and nose, as a sign of degradation or punishment.

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The rudimentary attempts at repair were made by a caste of potters in India, who first made a pattern of the missing nose and then applied it to the forehead or cheek. A similar portion of skin excised from these areas (and left attached at one point) was transplanted to the freshened edges of the nasal site. The passing of tubes into the lower part of the flap and application of pressure completed the operation.

The earliest accounts of rhinoplasty in Europe are those relating to the operations performed by Branca and his sons in Italy. He appears to have been the first to utilize a flap from the arm and its immediate attachment to the desired site. Casper Tagliacozzi, professor of anatomy at the University of Bologna, described this method and it has been called his method or the Italian Method. The both methods were described and modified for the next few centuries.

The next important advance in rhinoplasty was made by Dieffenbach in 1845. He developed the double-faced flap with the realization of the importance of an inner lining for the nasal cavity. In 1861, Ollier reported the transplantation of living bone for the construction of a nasal bridge.

These early attempts to build a nasal framework stimulated other surgeons to experiment with the transplantation of other osseous tissues. Koenig advocated the use of the outer table of the frontal bone together with its overlying skin for the building of a saddle nose; a second skin flap was to serve as the outer covering.

Progress continued along these lines with slight intermissions until 1896, when Israel transplanted a free bone graft taken from the anterior surface of the tibia. The graft was successful. Von Mangold's work followed. He utilized rib cartilage for the correction of a saddle nose with a surprisingly excellent result.

Particular credit belongs to Jacques Joseph of Berlin, who interested himself in plastic surgery of the face prior to World War I and

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brought his art to high perfection in the reconstruction hospitals of Germany. He originated most of the intranasal operations for the correction of nasal deformities and likewise devised the instrumentarium.

During World War II, a special division of maxillo facial surgery was organized by the Medical Department of the U.S. Army, and a similar service was set up at the Queens Hospital at Sidcup, England. The activities of these organizations are too recent and too familiar to require a lengthy discussion. Interested students from the whole world flocked there to observe and study the work that was being accomplished. The work of Blair, Ivy, Davis, Gillies, Joseph, Lexer, and many others have advanced the technic rapidly during the twentieth century. While these investigators did not originate any new principles, they demonstrated the advantages as well as the faults of the earlier methods.

RHINOPLASTY

As it was mentioned in the introduction, the most common procedure in plastic surgery is the cosmetic sculpturing of the shape of the nose. Jacques Joseph was the originator of the intranasal method. Previously, in order to remove a hump of the nasal dorsum, an external incision was made along the length of the hump and by means of a mallet and chisel, the hump was removed. This left an external scar which was disfiguring. Joseph devised an operation where the initial incisions were made bilaterally in the hiatus between the upper and lower lateral nasal cartilages. He then continued his incision so that the knife blade was between the skin and the bones of the nose. He elevated the skin over the whole nose, from the naso frontal angle to the columella. He, then, either elevated the periosteum over the bony hump or destroyed it. Then, using a small saw, he cut through the nasal hump and then resected and removed it. This removed the hump but left a flat area over the dorsum. Then, he made bilateral incisions, intranasally, over the front face of the maxilla; elevated the periosteum and now using angulated saws, he sawed through the nasal processes of the maxilla and then fractured them inward; thus narrowing the nose. He then cut a wedge off the anterior tip of the nasal septum and sewed the columella to it; thus shortening the nose. This procedure, with some modifications and additions, is the basis of the modern rhinoplasty. This operation was sufficient for noses having too much bone or support.

ALLOPLASTY

However, there has been a long history of trials with various materials when further support was needed. The first materials suggested were of an alloplastic nature. Letievant in 1879 used a

metal implant. The introduction of other materials, including gutta-percha, gold, silver, lead, amber, aluminum, celluloid, hard rubber, and paraffin, soon followed. It was only two decades ago, that a still living heavyweight boxing champion had paraffin instilled in his nasal dorsum to build up the nose.

Paraffin implants, a relatively simple and inexpensive procedure, consisted of injecting paraffin in a low melting state underneath the skin and then shaping it before solidification took place. While this method could almost satisfy our standards as far as aesthetics and simplicity are concerned, its great drawback is in the intolerability of the host tissues to the final hardened paraffin implant. In most cases, the tissues about the implant respond by the formation of a chronic granuloma which tends to become carcinomatous. Many operators, probably fascinated by the directness of the approach and ease of operation, have used this method to correct saddle noses and other bony defects of the malar and frontal bones.

Eitner and Joseph in 1915 recommended ivory for transplants. The inertness of the material made it ideal as an implant in bony defects; but it was of such hard material, that it was difficult to shape or carve. Occasionally, it would be extruded following a secondary infection, when it would not be tolerated by the tissues.

An alloplastic substance recommended by the author, and not, as yet, used widely is Acrylic. It can be modeled in the laboratory from a plaster cast of the face and can then be shaped to fit whatever bony defect there is. It is a non-reactive substance, being a methyl methacrylate implant, which can be shaped before coming into the operating room. It has been used successfully for implants in the dorsum of the nose; building up the upper lip or chin; and for malar and frontal bone defects. Only rarely, has it not been tolerated by the tissues.

Another inert substance, widely used, is tantalum steel. This has been previously used for bony defects in the cranium or the long bones of the body, and it has been well tolerated. Very recently, it has been commercially produced in the form of a gauze, which can be packed into a small wound and help fill out a soft tissue defect.

BONE GRAFTS

Many surgeons have shown preferences for autoplasmic implants. These are of human or animal origin and many times will be better tolerated by the host than inert substances.

Von Langenbeck in 1859 and Ollier in 1864 were the first to use bone as a supporting structure in nasal repair. Bone has been taken from the frontal bone, ulna, tibia, clavicle, sternum, phalanges, and ilium. The ilium is the method of choice, at present, and is used as the source

of bone in implants. Bone is a viable substance that requires a blood supply almost immediately and if none is forthcoming soon after transplantation, it will die. Therefore, bone and periosteum are transplanted together. However, bone is hard to shape and is not considered too satisfactory as an implant. Some surgeons are experimenting with scraping cancellous bone from under the crest of the ilium, mashing it to a pulp-like substance and inserting that as an implant. It can be modeled by external manipulation. That will be an ideal substance if it will stay viable.

CARTILAGE GRAFTS

Cartilage is an unrivaled grafting material, especially suited to replace bony losses about the head and to add prominence to external surfaces. Because cartilage is lymph-nourished, it "takes" readily, retains its original morphology and does not become absorbed easily or tend to shrink or disintegrate even in the absence of perichondrium. While it is true that decalcification and partial replacement by dense fibrous tissue may take place, nevertheless, these changes do not materially alter the shape of the graft. Its chief drawback is that, when used as a graft, it does not form an organic union with bone and becomes attached only through fibrous tissue.

The source of cartilage can be either homogenous or isogenous.

A homogenous graft is one taken from the costochondral cartilage of the host. At the same time of operation, it is whittled into shape and inserted into the area of defect. Many surgeons, including the author, have used isografts of human cadaver cartilage. Just as good or better results have been obtained with the cadaver cartilage. It is taken from a cadaver—the costochondral area, the perichondrium and all soft tissues are removed and it is placed in a solution of 1 part aqueous merthiolate (1:1000) and 4 parts sterile normal saline. The container is kept in a refrigerator and kept thus until it is used.

The refrigerated cartilage isografts are efficient and economical for the patient requiring reconstructive surgery. They eliminate the necessity of resection of the host's ribs, and allow a storehouse of easily available material, not influenced by race, age, color, sex, or blood grouping. Refrigerated cartilage isografts, at times, cause a slight local reaction but this is helpful in fixing the graft. They have less tendency to bend or curl than do autogenous grafts. They lend themselves favorably to sculpturing. Diced cartilage grafts have been used to fill in soft tissue or bony defects, such as malar or frontal bone defects, or to build up a receding chin. The cartilage is cut up into small cubes, similar to the process of dicing carrots; and then through a small incision they are forced into the area of

defect. They can then be molded from the outside and a favorable contour obtained. Strange to say, they may be cut into quite small cubes and yet have a good "take."

FAT GRAFTS

Neuber, in 1893, first attempted a free transplantation of fat, to build up an orbital cavity. Fat grafts have since been used for many purposes; to elevate depressed scars, to reshape the facial contour by filling out depressions, to obliterate dead spaces, etc. Only autogenous transplants have been used, the fat being obtained usually from the abdomen. The fat is removed and not handled too much. An incision is made over the depressed area and a pocket is made under the skin, and the fat is inserted. Usually, about one-half of the graft undergoes absorption, so that twice as much as is needed is used. The low vitality of the fat predisposes to infection, so that these grafts are not used too much.

Fascial grafts have limited use in plastic surgery of the face. Fascia lata of the thigh has been used as long strips to hold up and form a sling for facial muscles following a facial nerve paralysis.

However, to supplant autogenous fascia, there is now sold commercially, strips of fascia obtained from the ligamentum nuchae of horses, which serve the purpose; or one can use strips of tantalum for the same purpose.

FACIAL PROSTHESIS

There is another totally different type of prosthesis. That is, what Esser calls, the bloodless type. These are indicated where surgery itself is contraindicated, whether because of co-existing disease, the debility of age, or because the result by manipulation of flesh alone would cause an aesthetically undesirable result. The surgeon is the first to confess that reconstructive operations, such as that of the total ear, often at best carry the probability that the cosmetic result of an operative series will be only fair. No surgeon can make a total ear or nose out of flesh, bones, and cartilage which will have a passable cosmetic effect. By prosthetic techniques, however, an ear of latex rubber, or of polymerized vinyl resins can be made to match its mate with accuracy, quite passably colored and possessing the translucence and elasticity of the patient's normal ear. Such an ear, applied with a waterproof and perspirationproof adhesive substance, will better satisfy the patient and can be produced without hospitalization or loss of time from work. New materials such as vinyl alcohol, vinyl chloride, latex, neoprene, and methyl methacrylate are now being used. Even artificial eyelashes, artificial fingernails, toupee silk, colored lacquers, tints, and dyes from all industry are now combined to help make prostheses the important adjuncts of surgical practice that they deserve to

be. Ears, noses, orbital sockets, portions or whole faces are now being replaced by these prostheses. People who have disfigurements after removal of facial deformities, i.e., carcinomata, sarcomata, burns, syphilis, need not lead a life of confinement in an institution or room. The life-like prosthetics have allowed them to return to the living world and carry on their routine work.

Every doctor or medical student is cognizant of the appearance of a patient with a facial paralysis. He may see it as a part of a "Bell's Palsy" syndrome, or it may be secondary to: (a) Mastoid surgery, (b) operations in the parotid region, in which the nerve has been cut, (c) fractures of the base of the skull in the region of the Temporal bone, (d) pressure on the nerve from inflammatory or suppurative processes in the middle ear, or from abscesses or inflammations of the parotid gland, neck, or mandible. The routine methods of treatment such as heat, massage, electrical stimulation, etc., will not be discussed in this paper. We are interested in the alleviation of symptoms of the patient with a chronic facial paralysis, with the atrophic facial muscles, with the bulging and oft-bitten inner surface of the cheek on the affected side—the person who accumulates food between the cheek and gum due to loss of control of the facial muscles.

If muscles respond to stimulation, many surgeons attempt decompression of the bone over the suspected severed area and an end-to-end anastomosis is performed; or a small piece of transplanted nerve is placed between the severed ends to fill out the gap. This is called "nerve graft." Formerly, facial anastomosis was done with contiguous motor nerves such as the accessory or hypoglossal nerves. These have not been too satisfactory and generally are not used now.

Others have tried "muscular suspension" of the paralyzed muscles. In this procedure, one-half to one-third of the masticator muscles, those supplied by the motor branch of the trigeminal nerve, are transplanted into the angle of the mouth and to suspend the orbicularis oris and other muscles. This has not been as satisfactory as the next method.

FACIAL SUSPENSION

In this method, use has been made of autogenous fascia from the fascia lata of the thigh, or commercially, fibers from the ligamentum muchae of the horse, or kangaroo tendon, or most recently, tantalum wire and foil. The principles are the same. A vertical incision is made in the region of the temporal fascia. A long tunnel is made under the skin till a point around the external canthus of the mouth and under the midpoint of the lower lip is reached. Then a long instrument is inserted, carrying one of the materials to be used for the suspension. As this

is pushed through the tunnel, at various points it is inserted through the paralyzed muscles. When the most dependent point is reached, a small incision is made and the tendon or fascia is tied in place. From here, through the same tunnel, another supporting strand is pushed up to the initial incision in the temporal fascia. Thus the fascia forms a sling and is tied in place in a marked over-correction. A similar loop is initiated and placed around the muscles of the upper lip. A third loop is placed around the external facial muscles of the orbit to hold them in a sling. This procedure has been the most satisfactory.

Just briefly, a word about the patient with the prognathous or projecting underslung jaw. At present, there has been resection of a small portion of the vertical or horizontal ramus of the mandible, with the forcing back of the jaw until there is a corrected bite, and also a markedly improved cosmetic appearance.

For a receding upper lip or chin, shaped implants have been used, made of autogenous bone, autogenous or cadaver cartilage, or a sculptured acrylic implant. They are inserted through an inconspicuous skin incision into a pocket. Thrombin topical and other blood coagulants, inserted simultaneously have helped accelerate the fibrosis around the implant and thus fix it in place. Also, for a receding chin, men like Kazanjian have used oblique osteotomy of the horizontal rami of the mandible with advancement of the rami and correction of the bite.

SKIN GRAFTING

The present military conflict has given rise to a large group of traumatic lesions which ultimately require skin grafting. We will not attempt to discuss the use of various types of skin grafting and how obtained, except the most recent methods. Dr. Padgett, in the last few years, has developed a Dermatone, named after him. This consists of a large drum-like affair, on which is painted rubber cement. Rubber cement is also painted on the donor area—just enough so that the required pattern and no more is cut. The drum is placed on the skin and then picked up. Where contiguous areas have had rubber cement on them, they will adhere. A knife is attached to the drum, attached in such a fashion, that the depth of the skin graft can be calibrated. With a back and forth motion the knife cuts the graft and only that skin of the donor surface that has had rubber cement painted on it. Thus an even pattern of skin can be cut. After the skin has been cut, a fine spray of Thrombin topical is sprayed on the donor area, which stops exudation or serum formation and greatly accelerates healing. Some thrombin topical is also sprayed on the recipient area and when the graft is placed on it, very few

sutures are needed and there is small chance for serum to accumulate under the graft and prevent the "take." Others have used other media, such as plasma or dried red blood cells as a grafting medium or glue to hold the graft in place. Others, such as Strumia, Hodge, and Matthews, are working on methods for preserving human skin in a frozen state, to be thawed out later and used as autogenous grafts.

FACE LIFTS

An ailment which must come to every man is old age and with it, one of its most recognizable signs of "wrinkles." Operations for removal of wrinkles or "Rhyectomy" are of recent origin. Gersuny in 1899 injected paraffin subcutaneously to remove the wrinkled appearance. Experience later showed this to be a harmful procedure. The first reported case was that of Hollander in 1912. Some surgeons refuse to operate under any circumstances, feeling that wrinkling of the skin, like graying of the hair, is a normal concomitant of advancing years and that the operation is just to pander the patient's vanity. Others, however, feel that it is justifiable for the patient's economic and psychiatric disposition; especially in the cases of those who are prematurely aged. Gillies once stated: "The desire to look young and attractive is no prerogative of any one class. The world is made up of a penn'worth of all sorts, and it is not everybody's good fortune to grow more graceful and beautiful in advancing age. The operations for removal of eyelid wrinkles, cheek folds, and fat in the neck are justifiable if the patients are chosen with honest discrimination." The patients are told that the immediate effect is always good, but that after a variable period, depending on age, profession, mental and physical habits, the redundancy will recur and necessitate a repetition of the operation. To many people, a youthful appearance for three or four years is sufficient to warrant the operation. It is a long operation, but it is not particularly shocking to the patient.

The author's method is to start an incision in the hairline and continue it in front the auricle; around the lobule and behind the ear into the area over the mastoid region. The skin is undercut for a variable area as required and excised. A few fascial sutures are placed and then the skin is closed with a continuous black silk suture. Care must be taken that the lobule of the ear is not caught in the healing scar. Separate incisions are made for removing wrinkles and bags under the eyes. An incision is made just below and parallel to the lower lid margin. The skin is undercut and then the muscle fibers of the orbicularis oculi are teased apart. A small amount of intra-orbital fat will herniate out and be excised. Then an appropriate amount of skin is excised and the wound is closed. For wrinkles

of the upper lid, wedges of skin are removed. Proper postoperative care will cause very little of the incisional scars to remain. Postoperatively, there is no reaction. The skin will appear taut and the face expressionless for several weeks, after which the normal facial expression will return.

VASCULAR GROWTHS

Congenital vascular growths are primarily within the domain of dermatology. Angiomata, both vascular and lymphatic, are usually seen first by the pediatrician, or dermatologist. Surgical excision is superior to irradiation in that it does not involve a lengthy and expensive course of treatments; and it is preferable to the introduction of sclerosing solutions and cauterization, since it leaves a linear scar instead of a slough. Unfortunately, however, the size and location of the growth are such as to prohibit primary surgical excision. Such a procedure is practicable only when the growth is small enough to permit a direct approximation of the wound margins after its removal.

It is well to give these tumors preliminary therapy, if they are large, before removal is attempted.

1. Radium—as a surface pack, in tubes applied to the lesion, and as needles or as radon seeds implanted into the tumor, has been used.

2. Sclerosing solutions have been used successfully. Numerous agents as 20 per cent quinin hydrochloride and ethyl carbamate, sodium chloride, 50 per cent dextrose solution, boiling water, etc.

3. Electro-coagulation, using high frequency currents, is a good method for the eradication of cavernous angiomata in adults.

4. Cauterization may be resorted to in the treatment of capillary angiomata when excision is impracticable or when irradiation is unavailable.

The agents more used are: 1. Carbon dioxide snow, 2. trichloroacetic acid, and 3. electrocautery.

After these vascular growths have been treated by one of the above dryingout methods, to rob them of their bleeding tendencies, then, they are ready for surgery. If small, they can be excised in toto and the skin undercut and closed. If large, they can be excised partially and the wound allowed to heal. This is repeated in several operations, till the whole scar is removed. This is especially efficacious where one-half a lip is markedly thickened and gradual thinning of the lip is done by excising linear segments. If the scar is a large, blotchy one, which may cover all or a large part of the cheek; then it is not worthwhile to attempt complete excision and a skin graft, because the skin graft may not be an improvement over the original scar. In those cases, the plastic surgeon should know enough

about the use of cosmetics and advise, especially the woman patient, how to use various scar covers like "Covermark" which is a commercial name for one such product. The author has seen female patients use "Covermark" and a pancake powder make-up so that no evidence of a blotchy, purple skin is seen. These girls can go into society without thinking twice about their scarred faces.

OTOPLASTY

The auricle of the ear is prominent, easily seen and quite fragile in its make-up, and responds easily to trauma and injury by forming scars. Any bruising trauma may cause a deformity known as cauliflower ear as seen in boxers, wrestlers, and football players. There is a tearing of blood vessels and the organization of a clot under the perichondrium. This may become organized and form a cauliflower like appearance. Under aseptic conditions, a flap of skin and perichondrium is raised over the deformed area, the osteo-chondromatous masses are shaved, curetted, or chiseled away until the ear is normal in shape. The flaps are sutured back in place and a tight dressing applied to prevent reaccumulation of blood and serum.

The outer edge of the auricle consists of two layers of skin with cartilage between them. This is the same combination and the skin has the same appearance as that of the rim of the nostrils. With a deformity or need for replacement of a wedge in the nostril, a wedge of the outer rim of the auricle is excised and fitted in to fill out the contour of the rim of the nostril.

The correction of auricular deformities requiring merely a reduction in size or a change in shape or position is comparatively simple; but the restoration of a partial or complete loss of an auricle is extremely difficult. Joseph Beck once stated: "The great difficulty is to obtain a good cosmetic result when the external ear is more than two-thirds absent. Surgery, however, has not proved equal to the task. The long, tedious multiple procedures do not produce results that are esthetically acceptable and only serve to substitute monstrosity for deformity." Thus, the author recommends a suitably matched prosthesis as described previously.

Outstanding ears, or ears which form more than a 30 degree angle with the head are a fairly common sight and are seen at frequent intervals by the plastic surgeon. Attempts to correct this condition by means of compression bandages, elastic caps, adhesive dressings, ear muffs, etc., even in infancy are useless. The only measure of permanent value is the reduction of the size of the angle by removal of a crescent-shaped section of post-auricular skin and cartilage, enough to break the spring of the whole auricular cartilage.

Davis and Kitlowski devised a method of securing orientation for the position of the new

antihelix and also for gauging the amount of skin and cartilage to be excised. The same method is used by the author and consists of the following: an hypodermic needle, at least one inch long, is pushed through the proposed new antihelix, after the ear is bent back to the proposed new angle. A drop of methylene blue or any dye is placed on it, and as the needle is withdrawn, a mark remains on the skin on the back of the auricle. About five or six times this process is repeated, up the length of the new antihelix and when these lines are joined together, they form the line of incision and later of excision of skin. The skin is incised behind the ear and elevated for several millimeters in each direction. Then an incision is made in the perichondrium and this is elevated the whole length of the cartilage, for several millimeters on each side. Then a small sliver of cartilage is removed, and the outer half of the cartilage is placed behind the medial half. About three fine linen sutures are used to sew the perichondrium together; then sufficient skin is removed behind the ear so that with the ear in the new position, there will be no excess of skin. The skin is closed with interrupted skin sutures. The ears are properly dressed with a mastoid type of pressure dressings, which are kept on for two weeks. Later, a skull cap or elastic dressing is worn at night over the ears for a month.

The completion of discussion of the various topics in plastic surgery does not mean that the topic has been exhausted. Nothing has been said about the art of Z-plasty and multiple excisions in the movement of skin surfaces and the relaxation of scars; of skin flaps and tubes, of the repair of eye-lid or lip repairs, of palatal and other maxillofacial repairs. This has been a presentation of several interesting topics in plastic surgery of the face; enough to show the principles employed and the wide scope that the imagination and ingenuity of the surgeon will allow him in the repair of the cosmetic defects. A plastic surgeon need not be an artist or sculptor to be successful; he need keep only in mind that the symmetry and normal appearance of the organs is necessary. He must know a few principles of plastic surgery and with what autogenous and isogenous materials he has to work. The author believes that to many physicians this is new material and because of a desire to make the subject more familiar, this paper was written.

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Tuberculosis Abstracts

A Review for Physicians Issued Monthly by the National Tuberculosis Association

IN the war against tuberculosis the mass X-ray survey may well be considered as a reconnaissance undertaken to discover where the enemy is hidden, so that practicing physicians in the area may attack the disease most effectively. It is upon their efforts, supplemented by services within the community and reinforced by public awareness of the problem, that success or failure in the control of tuberculosis depends.

THE COMMUNITY AS A FORCE IN THE CONTROL OF TUBERCULOSIS

Modern epidemiological methods in the control of the communicable diseases make it imperative for workers in the field to know where, when, who, and how many any given disease attacks. The swiftest and most efficient way to the heart of this problem in the field of tuberculosis is through X-ray surveys of large population groups, preferably those which compose large metropolitan areas. These present all manner of social complexity, racial variation, and economic resources.

At the beginning of organized control movements, it was believed that the most effective means of discovering the exact nature of the tuberculosis problem in the United States was through surveys of industrial, occupational and racial groups. However, the knowledge thus secured was at best spotty and was likely to be misleading when the whole population of the country was considered. It was thereupon determined to delve into those vast reservoirs of human beings which are our great cities. Here are all the maladies that are suffered by mankind. Through a prompt discovery of the tuberculosis problem in the larger cities of our country, a reasonably exact knowledge of the extent of the problem could be realized, public action stimulated, and professional forces joined.

City-wide X-ray surveys can be conducted with relative economy of means and money. Concentration of personnel, machinery, and educational devices within densely populous communities provides, in certain respects, quicker and more valuable results than do studies conducted in sparsely settled areas. Previous experience in cities already surveyed indicates that if present facilities are fully utilized, the increased case load of tuberculosis will not present a grave problem to the community. Seventy per cent of all new cases discovered by mass X-ray survey are minimal and do not constitute a grievous public health problem. Most of these cases will be noninfectious; the disease process will be incipient; and the probability of serious progression, with adequate follow-up, will be slight. Such cases

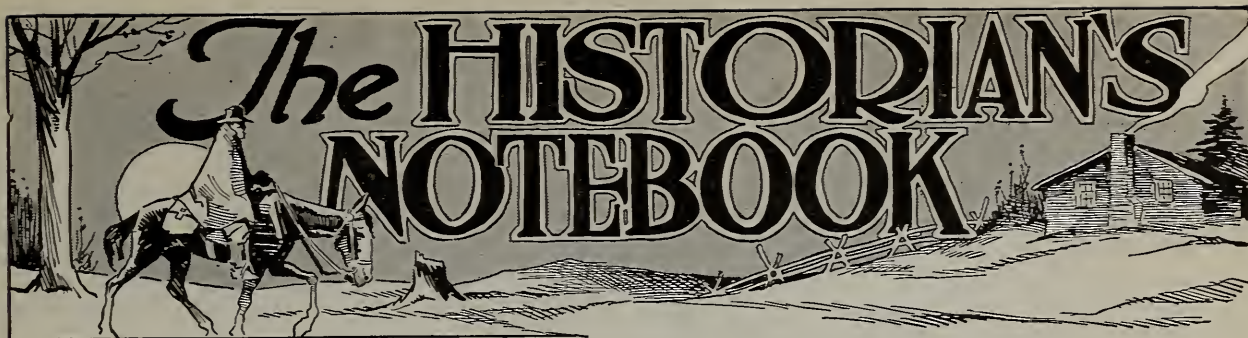
can be cared for by private physicians and public clinics, assisted by public health nurses and medical social workers. Sanatorium beds now occupied by noninfectious cases can be given over to far-advanced virulent disease which constitutes a menace to the local population.

Minimal, noninfectious cases are private physician's cases, not sanatorium cases. The private practitioner can be a major force in the future control of tuberculosis in the communities of our country if he participates in follow-up activities after the survey has been completed. Through his efforts, minimal tuberculosis can be checked and, in individual cases, never become serious. Under the physician's care, needless distress and tragedy can be avoided.

Often communities can afford to enlarge present clinic and hospital facilities when they cannot afford to build new institutions. Recruiting professional personnel is always a serious problem everywhere. However, resolute efforts to procure and then train professional workers will be productive of fruitful results.

An aroused community makes for organized action. An informed community acts collectively as a social weapon against any threat to its existence. A community aware of the problem confronting it and organized for effective action is the principal force in a program to control tuberculosis. Isolated leaders and their followers, no matter how well trained or how profoundly dedicated, have little potency without the strength inherent in the human and economic resources of mobilized communities. By now it must be plain that the fight against tuberculosis is a social and economic movement as well as a disease problem. We now have enough information to be confident that an awakened awareness of the people is the chief tool for triumph.—*The Community as a Force in the Control of Tuberculosis, Francis J. Weber, M. D., Editorial Public Health Reports, September 5, 1947.*

Advanced urinary tract disease may exist and yet the urine be normal. For this reason it is wise to repeat urine analysis several times when the clinical picture is obscure and the diagnosis uncertain. When caring for a patient over a period of time it is often noticed that both erythrocytes and leukocytes appear in the urine in "showers" and that when these are washed away the urine is normal for a time. A specimen taken during a normal period would tend to throw one off the track.—D. W. Atcheson, M. D., *Riverside; California Medicine*, Vol. 69, No. 4, Oct., 1948.



Laura Marion Plantz, M. D.

WALTER G. WHEATON

LAURA MARION PLANTZ was born in Lyndon, Vermont, May 8, 1829. She was one of the eleven children of Nelson and Bersheba (Moore) Wheeler, who later removed to Putney, Vermont. The father became the village blacksmith and wagon-maker and the mother the town nurse and dispenser of the current root and herb remedies. The family was large and in moderate circumstances, compelling the daughter Laura to earn her own living and help support the rest of the family.

Laura attended school in Barton Landing, Putney, and at West Brattleboro, Vermont, where she worked for her board in the home of Reverend Roswell Harris, principal of the Academy, at the same time teaching a class in that school. Finishing her course, she taught school in the "Dewey District" in northern Vermont.

Going west to Jerseyville, Illinois, she was principal of a Young Ladies Seminary, later returning to Putney on account of ill health.

October 26, 1853, at Saxton's River, Vermont, she married William Fairchild and removed to New Haven, Conn., where her husband was a merchant. Mr. Fairchild died less than two years afterward. His widow thereupon decided to become a "woman physician." Owing to the prejudice against women entering any profession, especially that of medicine, such decision was a daring one and required great courage and self-reliance.

She went to Lowell, Massachusetts, and was a "factory girl," reading medicine with a preceptor, thence to Boston continuing her studies and attending medical lectures.

From Boston, she went to Philadelphia and entered the Medical University of Philadelphia, graduating April 1, 1860.

She immediately accepted the position of resident physician and superintendent of an institution for diseases of women at 91st Street, New York City. She resigned that position to

become resident physician and matron at the Home for the Friendless, New York City. Here, she was presented \$50 for "the superior sanitary condition" of the institution under her management.

The Civil War was in progress and Mrs. Fairchild transferred her activities to Bellevue



Hospital, where she organized and trained nurses to go to the front with the Army.

She decided to go to Rushford, Minnesota, and practice medicine. There she met and married Col. William G. Wheaton, civil engineer for the Peoria and Hannibal Railroad. The marriage occurred July 27, 1862, and Doctor

Wheaton and husband went to Peoria, Illinois, to live.

Afterward they concluded to remove to Kalamazoo, Michigan, where Doctor Wheaton resumed the practice of medicine. A home was built on a hill farm of twelve acres, just on the edge of town, where a vineyard of five acres was set out and the remainder of the farm devoted to fruit raising.

In the 1870's Doctor Wheaton became much interested in the Woman's Suffrage movement as advocated by Susan B. Anthony and Elizabeth Cady Stanton. Apparently with inconsistency, she opposed these leaders, in the lecture field, speaking in Washington, Chicago, and many Illinois cities. In 1870, Illinois held a Constitutional Convention. Doctor Wheaton went before the members of that convention and made a speech against adoption of a plank recognizing women's right to vote, etc. Joseph Medill, editor of the *Chicago Tribune*, himself a member of that convention, wrote July 1, 1870: "Mrs. Doctor Wheaton of Kalamazoo, Michigan, whose lecture last May, before the Illinois Constitutional Convention against woman's suffrage, had so potential effect in causing that body to reverse its previous action." That defeated the Woman's Suffrage plank proposed at that time. Doctor Wheaton's lectures were well received wherever given, especially "The True Woman" and "Perils of the Hour."

Col. Wheaton's health failed in 1875 and Doctor Wheaton took him and their 9-year old son, Walter, to San Francisco, where Col. Wheaton died September 28, 1875. After his burial in Rockford, Illinois, Doctor Wheaton returned once more to Putney. The death of her sister and her mother occurred soon afterward and she concluded to go back to Kalamazoo and rebuild her practice again.

She married Judge T. A. Plantz December 19, 1876, and she and her son removed to Pomeroy, Ohio, the home of Judge Plantz. Mr. Plantz had been editor and publisher of the *Pomeroy Telegraph*; Judge of the Common Pleas Court; member of the Ohio Legislature, 1857, and 1859; member of the House of Representative, 39th Congress, 1865-1866; and president of the First City Bank of Pomeroy from 1879 to the time of his death, June 19, 1887.

Doctor Plantz had an office practice in Pomeroy for about fourteen years, specializing in diseases of women and children.

Putney was again a "haven of refuge" and she returned there in 1891, built a new house on the site of the old homestead and "hung out her shingle" and practiced there until her removal to the home of her son, Walter G. Wheaton, in Columbus, Ohio, in 1921. Thus ended 61 years of medical practice, retiring at the age

of 92 years. She was the first registered woman physician in Minnesota, Michigan, Vermont, and probably Illinois.

Two years later, at the home of her son, she fell from a stairway and fractured a hip, resulting in her death May 23, 1923. Her funeral was from the Congregational Church in Putney three days later.

During the last thirty years of her life in Putney, Doctor Plantz was well known and popular and much in demand as a public speaker at Grand Army of the Republic state conventions; meetings of Historical Societies, etc. She was a member of the Woman's Relief Corps, the Order of Eastern Star, etc.

Coming from "Revolutionary stock" she was interested in the organization of the Daughters of the American Revolution and was accepted as a Charter Member, Certificate No. 228, dated April 16, 1891. Her certificate of membership was dated January 30, 1892.

The Brattleboro Chapter of the D.A.R. made her a life member and installed a chair in her memory in Continental Memorial Hall in Washington, D. C., in 1896. (Section J, Row Q, Chair 1.)

Doctor Plantz was a lady of refinement and culture and maintained her mental faculties to the end of her long and useful life. She kept posted on the advancements in the medical profession and was interested in public affairs and news of the day.

Her passing caused grief and regret to widely scattered friends who always remembered her skillful treatment, loving care and sympathy.

* * *

Copy of the Diploma of

Doctor Laura Marion Plantz
(The former Laura M. Fairchild)

April 1, 1860

Omnibus ad quos hae literae perveniant
Salutem

Sciote quod nos
Praeses et Professores Universitatis Medicae
Pennanae, Philadelphia

LAURA M. FAIRCHILD

Ingenio bono ac scientia utile praeditum moribusque prolis ornatumque etiam, scientia exima in Arte Medica aequae Chirurgica a se acquisita nobisque examinatione privatum habita plenius manifesta, se dignum amplis simis academicis estendit

Artis Medicinae Doctorem
Creavimus et Constituimus

Eique supra dicto—Laura M. Fairchild—hujus diplomatis virtute singula JURA, HONORES et PRIVILEGIA ad gradum DOCTORES

in ARTE MEDENDI inter nos et ubique gentium libintissime et plenissime concessimus et rata fecimus.

In cujus reifidem, haec membrana chirographis nostris subscripta et sigillo Collegii nostri signata, testimonio sit.

Datum in Aula Medicinali nostra urbe Philadelphia, Pridie Cal. Aprilis Anno Humanae salutis MDCCCLX.

M. Newkirk, Praeces.

Guiliemus Solimoele, Phil et MD, Patholog, gen et spec, Prof.

J. Emerso Kent, MD, Instit et Prax Medicinos, Prof.

S. Pancoast, MD, Princ et Prax Chirurg, Prof.

Josephus S. Longshore, MD, Obstet. et Mul et Infans Morle, Prof.

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M. H. Andrews, M.D. Ment. Philos. et Med. Jurispre, Prof.

S E A L

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University of Phila.
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Ascites

J. Q. Southard, M.D., of Raymonds, Union County, reports the following case of Ascites, in which remarkably large quantities of fluid were withdrawn: Mrs. W., aged 53, was tapped February 18th, 1876, 38½ pounds of yellow albuminous fluid being withdrawn; March 8th, 1876, 39 pounds were removed; March 29th, 37½ pounds; and April 23rd, 36½ pounds—making 151½ pounds withdrawn in a little over nine weeks. The patient is reported as still "Comfortable and hopeful."—*The Ohio Medical Recorder, Volume 1, Number 1, June, 1876.*

* * *

In the '70's, medical schools sometimes boasted of their "Now terms in nine months." The editor of *Medical and Surgical Reports*, commenting upon the commencement of one of these colleges, said the system "is based on the analogy of nature; for, as it requires but nine months for an embryo to become an infant, it should not ask more for a dunce to become a doctor."

Books of History

Nora Wydenbruck has given us an interesting historical story of eighteenth century life centering around between Dr. Mesmer, a psychological therapist, Mozart, who was his first patron, and the blind piano virtuoso, Marie Theresa Paradis, for whom Mozart wrote his first piano concerto in B Flat Major. (*Doctor Mesmer, 8s 6d net, John Westhouse, 46 Chancery Lane, London WC2, England.*) Although obviously based upon a great deal of historical research, it is written in such a lively and original manner as to read like a novel. The central theme is a study of Dr. Mesmer's spectacular cure of Marie Paradis and the blind girl's subsequent relapse and her return to blindness and to fame. Mesmer was forced to leave Vienna after his fiasco. We see him at the height of his career and again when his vogue is declining. Could it be that the tale carries a warning for those of our profession who have taken up self-hypnosis as a technique for healing the sick?

* * *

Pioneer Life in Kentucky, 1785-1800, by Daniel Drake, M. D., (\$5.00. *Henry Schuman, Inc., New York City*) has been edited from the original manuscript by Emmet Field Horine, M. D., of Brooks, Kentucky. These are the "reminiscential" letters written by Drake in response to the urgent requests of his children for a family record. The first printing of these was arranged by his son, Charles Daniel Drake, and appeared in 1870 as Volume No. 6 of the Ohio Valley Historical Series. It has long been a collector's item. A reprint was published in 1907 but as sometimes happens this is still rarer than the first edition. When Dr. Hobine compared this text with the original manuscript, he found literally hundreds of changes had been made without notations. So, from a historical point of view this edition is by far the more valuable and no doubt will soon be a collector's item itself.

* * *

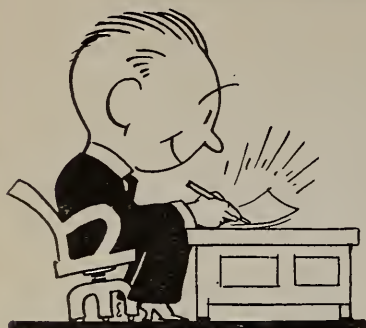
Authority in TVA Land, by W. V. Howard, (*Frank Glen Publishing Co., Inc., Kansas City, Missouri*) gives the inside story of the Tennessee Valley Authority that is pretty damning to its cause. Yet it is one that everyone interested in Government in business should know.

* * *

Jungle Doctor, by Norman E. King, (\$1.75. *Zondervan Publishing House, Grand Rapids, Michigan*) is a fictionalized picture of the work of medical missionaries.

* * *

Occupational Therapy Source Book, by Sidney Licht, M.D., (\$10.00. *Williams and Wilkins Company, Baltimore, Maryland*) from earliest times. Ten sources are present with an excellent essay on the early history of the subject.



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Costs of transporting exhibits to the meeting must be borne by individual exhibitors as well as the costs of cards, signs, etc., which are a part of the exhibit.

The Ohio State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, view boxes, current, furniture, decorations, etc., providing all items are approved in advance by the chairman of the committee. Watchman service will be provided for the exhibit.

Next Congress and State Legislature . . .

Many New Faces as Result of November 2 Election; Unfinished Business of National Body Outlined; Possible New Measures Discussed

UNLESS the official count of the ballots cast by Ohioans on November 2 should change the totals—which is quite unlikely—Democrats will have a 12-to-11 edge over Republicans in Ohio's 23-member delegation in the next Congress which will convene next January, and will be in control of both houses of the 98th Ohio General Assembly which will begin its work shortly after the first of the year.

The unofficial count shows the setup of the House of Representatives of the State Legislature to be 69 Democrats and 66 Republicans; that of the Senate 18 Democrats and 15 Republicans. There is a possibility these Democratic majorities will be increased when the official count is concluded.

MANY FIRST-TERMERS

There will be a substantial number of first-termers in the Ohio General Assembly. This means that many of the members will not be too familiar with even old issues which are bound to arise during the legislative session. Because the Republicans have been in control of both houses of the Ohio Legislature with substantial majorities for the past several sessions, the Democrats may find it difficult to supply experienced and seasoned chairmen for some of the committees and may have to use first-termers as chairmen of a few committees. Also there will be new faces in the positions of Speaker and Speaker Pro Tem of the House and President Pro Tem of the Senate—powerful assignments when it comes to the organization of those bodies in deciding policy matters and in the selection of committee personnel.

Of the 12 Democratic Congressmen-elect, four will be first-termers. They are Earl T. Wagner, Cincinnati attorney; Edward Breen, ex-hotel manager and former mayor of Dayton; Thomas H. Burke, vice major of Toledo and a labor union executive; and Wayne L. Hays, Flushing, former State Senator. Four others are returning to Congress after a lapse of a number of years. They are: Stephen M. Young, Cleveland; James G. Polk, Highland; John McSweeney, Wooster; and Robert T. Secrest, Senecaville. Democratic incumbents re-elected were Robert Crosser and Michael A. Feighan, Cleveland; Walter B. Huber, Akron; and Michael J. Kirwin, Youngstown. The 11 Republicans in the Ohio Congressional delegation served in the 80th or previous Congresses.

WHAT WILL CONGRESS DO?

Naturally, members of the medical profession are asking the question: "What will the next Con-

gress do on medical and health legislation?" There is no answer to that question at this time. A bulletin issued by the Washington Office of the Council on Medical Service of the A. M. A. makes the following observations on that point:

"The 81st Congress, which will convene on January 3rd, will have approximately twenty per cent new members in each House. Organization of the Houses is likely to be a troublesome problem; especially is this apt to be true in the Senate. The committee personnel will not be announced until organization is complete. The committees in which we have the most interest are likely to be manned by the people who directed them in the 79th Congress. However, there will be some changes.

"In our opinion, it would be neither wise nor safe to attempt to forecast what this Congress will do in the health field before we read what the President will recommend in his message to Congress. Both political platforms recommended liberal changes in our present methods of providing medical care and a governmental responsibility for making adequate medical care more available to the public. We must wait and see how Congress will undertake to implement the platform plank. In the meantime the medical profession should recognize its opportunity and responsibility to inform the members of Congress, and especially the new members, on the problems involved in changing our medical care program. It must be recognized that we are actively changing the system ourselves through our development of prepayment plans and group practice. Our Congressmen should be familiar with the progress we are making and the plans we have for the future in this direction. They should also know of the hospital construction plans in their communities, and it is exceedingly important that they should be thoroughly familiar with the local methods of providing medical care for veterans.

"In thus providing our Congressmen with information, it would be well to enlist the assistance of public leaders. If the Congressman recognizes that the profession has the good will and support of other influential segments of his constituency, it can expect his assistance in promoting legislation favorable to public welfare. It is essential, therefore, that the public be so fully convinced that our program is for the improvement of the general welfare, rather than the advancement of our private interests, that it will heartily give its open approval and join with us in accomplishing its realization. When physicians are invited to Washington to testify before Congressional committees, they are given the same consideration as any other witnesses, but the value of their testimony is multiplied many times over when the members of the committees receive from prominent individuals and organizations of their districts endorsements of the sentiment expressed by the physicians in the testimony. Naturally a man relying upon public confidence for his election to office will be loath to ignore the wishes of those people who elected

him. Obviously the advocates of Federal health insurance programs will interpret the results of the present election as favorable to their programs, but they may be mistaken. We owe it to our patients to aid in organizing public sentiment for what we know to be to their best interests."

UNFINISHED BUSINESS

The same bulletin enumerates some of the "unfinished business" of the present Congress which will come before the 81st Congress for consideration. Among the items mentioned are the following:

THE HOOVER COMMISSION

A Commission on Organization of the Executive Branch of the Government was established by Public Law No. 162, 80th Congress, to promote economy, efficiency, and improved service in the transaction of the public business in the various agencies and bureaus of the executive branch. The report of this Commission, to be submitted to the 81st Congress by January 13, 1949, will undoubtedly recommend the elimination of some government health activities and the consolidation of others. It will also comment on the creation of a department or secretariat of health.

ADVISORY COUNCIL ON SOCIAL SECURITY

This Council, created by S. Res. 141, was directed to make a full and complete investigation of Social Security with special reference to coverage, benefits, and taxes. Report is being submitted in sections. Three sections have been published thus far. It recommends that the government increase its interest in extending social security coverage, financial aid to those suffering total disability, and aid to dependent children.

SMITH COMMITTEE ON HEALTH

S. Res. 249 authorized the Subcommittee on Health of the Committee on Labor and Public Welfare of the Senate to continue its study of national health problems and of the relevant legislative proposals. It is to report to the full Committee on Labor and Public Welfare by March 15, 1949. The results achieved through grants-in-aid and other forms of subsidy are receiving special attention.

NATIONAL HEALTH BILL

A new health insurance bill is certain to be drafted along the lines adopted by the Federal Security Administrator in his report to the President on the National Health Assembly. His report, the Administrator admits, will not necessarily accord with the report to be submitted by the Executive Committee of the Assembly. An interested visitor to all sections of the Assembly while they were in action found a majority supporting the proposition that a health

program to be most efficient must function on a community rather than on a national basis. Other bills will be introduced as suggested by the recommendations that the President may make in his message to the Congress.

DRAFT OF PHYSICIANS

The Department of Defense is confronted with a very acute problem in providing adequate care for the draftees whom it will collect during the next year. It was hoped that a sufficient number of physicians would volunteer for this service. If an adequate number cannot be secured in any other way, the Department of Defense may be obliged to propose a draft bill.

Various plans for deferring medical students from the draft are being considered. The wisdom of permitting students who are pursuing a medical education to continue without interruption is obvious, but there are also students engaged in other scientific fields whose importance cannot be overlooked. Where to draw the line between the essential and non-essential is a problem.

MEDICAL EXAMINATION OF SCHOOL CHILDREN

When the 80th Congress adjourned it was considering bills (S. 1290 and H. R. 1980—School Health Act) authorizing the states to set up programs for the medical examination of school children, or children of school age. Hearings were held on the bills, but the committees did not take action. It can be expected that the subject will be continued by the next Congress. The American Parent Committee, promoter of one of the bills, will hold two one-day conferences this month, one in Washington and the other in New York City, to preview legislation for children in the 81st Congress.

DISABILITY INSURANCE

Temporary or partial disability: One section of the National Health Program (S. 1734 and H. R. 4390) before the 80th Congress, provided for the payment of cash benefits to workers for the time that they might be unemployed because of illness. Three states (Rhode Island, California, and New Jersey) now have insurance laws of this character. Permanent and total disability: Two bills (S. 1679 and H. R. 4303) outlined a program of benefits for persons totally disabled. The Senate Advisory Council (see above) recommends that legislation be considered in this field.

MEDICAL CARE FOR VETERANS

Two outstanding problems present themselves for solution in providing medical care for veterans.

(1) Hospitalization. The Veterans Administration has authority under Public Law No. 346, 78th Congress, to build an adequate number

of hospitals. As presently visualized, there will ultimately be approximately 300,000 beds at a cost of upwards of one billion dollars. This building program is being developed as rapidly as possible although the Veterans Administration reports that it now has more beds available than it can staff with doctors and nurses, and there are also reports to the effect that many operating hospitals have proportionately few service-connected patients. An unexpected and undesirable competition arises between the Administration's hospital building program and the development of the Hill-Burton Act. In some instances the two construction plans are operating in the same community.

(2) The other problem that is likely to engage the attention of the Congressmen is that of providing veterans with medical care for non-service-connected conditions. At present the unoccupied beds in veterans' hospitals can be made available to veterans suffering with non-service-connected conditions, if they declare themselves financially unable to procure adequate care. Reports from the Veterans Administration show that more than three-fourths of the veterans cared for in veterans general medical and surgical facilities are hospitalized for non-service-connected ailments. The government's decision as to whether it will provide all manner of medical care for the veterans or enforce the law with regard to indigency will very definitely influence the administration of the Hill-Burton Act.

CARE OF "MEDICALLY INDIGENT"

The National Health Insurance Bill (S. 1520) proposed that the Federal Government assist the states in providing medical care for all those declared to be medical indigents. No satisfactory comprehensive definition of "medical indigent" has been developed. In the meantime the Senate Advisory Council on Social Security, mentioned above, is recommending increases in the amount to be allowed for medical care to certain categories of indigents, namely, the recipients of old age assistance, the blind, and dependent children.

MEDICAL EDUCATION

Proposals have frequently been made to Congress that the number of medical schools should be increased, and the National Health Bill of last year carried a provision for this purpose. Senator Thomas (Utah), who may be the new chairman of the Committee on Labor and Public Welfare, introduced a bill at the close of the last Congress providing grants and scholarships for medical education. The Senator will very likely reintroduce his bill.

AID TO PUBLIC HEALTH UNITS

Three bills authorizing more financial aid to local public health units (S. 2189, H. R. 5644 and

H. R. 5678) did not get beyond the hearing stage, and it can be expected that similar bills will be introduced early in the session.

American College of Surgeons Initiates 50 Ohioans

At the 34th Convocation of the American College of Surgeons, October 18-22, in Los Angeles, 943 fellowships and seven honorary fellowships were conferred—the largest class of initiates since 1914.

Initiates include the following 50 from Ohio: Drs. Fred W. Alexander, Cleveland; James O. Barr, Chagrin Falls; Thomas S. Brownell, Akron; Joseph J. Brumbaugh, Canton; Alvin J. Carlson, Dayton; Donald C. Darrah, Cleveland; Winfred M. Dowlin, Canton; Gwilym A. Edwards, Van Wert; Edwin B. Egli, Lisbon; Walter F. Galbreath, Findlay; Thomas S. Gerspacher, Cleveland; Lawrence H. Goodman, Findlay; James S. Greetham, Marion.

George B. Haydon, Cincinnati; Nicholas H. Holmes, Chillicothe; Arthur G. James, Columbus; William P. Jennings, Cincinnati; Robert A. Keating, Columbus; Walter A. Keitzer, Akron; Karl W. Keller, Canton; Roscoe J. Kennedy, Cleveland; Thomas A. King, Columbiana; Erwin J. Kraker, Akron; Henry B. Lacey, Columbus; Middleton H. Lambright, Jr., Cleveland; Gustave S. Link, Toledo.

Bruce C. Martin, Columbus; Valerian J. Mastny, Cleveland; H. G. McCandless, Cincinnati; Edwin L. Mollin, Akron; Melvin A. Mulvanian, Lima; Philip F. Partington, Shaker Heights; Louis C. Ravin, Toledo; Philip J. Robechek, Cleveland; Arthur A. Roth, Cleveland; Richard T. Sauer, Dayton; John L. Scarnecchia, Youngstown; Allen L. Schaffer, Warren.

Clarence W. Sears, Youngstown; Myron A. Shilling, Ashland; Richard H. Stahl, Cuyahoga Falls; George A. Tischler, Cleveland; John A. Topinka, Cleveland; Harry W. Topolosky, Columbus; Oscar A. Turner, Youngstown; Gordon T. Wagner, Brunswick; Frank M. Warner, Barberton; John E. Williams, Cleveland; Frederick C. Witwer, Akron; and Charles S. Wohl, Toledo.

Among members of the Board of Governors for the term expiring in 1951 are the following Ohioans; Dr. Charles C. Higgins, Cleveland; Dr. Thomas E. Jones, Cleveland; and Dr. Robert M. Zollinger, Columbus. Dr. B. Noland Carter, Cincinnati, and Dr. Elmer R. Arn, Dayton, were named to fill unexpired terms ending in 1950.

To foster training of medical students in the mental aspects of disease, Federal grants for undergraduate courses are now being offered to medical schools by the Public Health Service. Formerly, grants to medical schools were utilized primarily for graduate training in psychiatry.

Physicians' Assistants . . .

Cleveland Academy Survey Points to Qualifications Which Members Expect of Office Girls; Sheds Interesting Lights on Training Needs

A GREAT deal of emphasis has been directed toward the importance to the physician of maintaining a capable assistant or capable assistants in his office. Sidelights have been thrown on this problem both from the standpoint of the office assistant as an aid to the doctor and and as a person who can and will maintain good relationships between the doctor and his patients.

Some interesting and enlightening information on this subject has been revealed by a survey recently conducted within the Academy of Medicine of Cleveland and reported in the November issue of the Academy's *Bulletin*. The survey and conclusions drawn from a study of the results were made by the Publications Committee headed by Dr. G. L. Sackett, and by H. Van Y. Caldwell, executive secretary of the Academy.

CONCLUSIONS DRAWN

"Many members took the opportunity to stress what the Committee had assumed, that intelligence and personality counted first in the selection of an assistant," the report emphasized. From the survey the Committee drew the following conclusions:

1. There is little evidence to indicate the need for technical training of doctors' assistants.
2. If such a need does arise, all schools training girls who enter employment of physicians might well consider establishing courses in simple laboratory procedures under proper supervision.
3. The doctor still finds as his first need, an intelligent, personable assistant trained much as the employees in commercial or other professional offices.

TYPES OF ASSISTANTS

From the survey it would appear that the following types of personnel are those most commonly found in the offices of physicians in a metropolitan community such as Cleveland:

Receptionist—In large offices where several girls are employed, one may spend most of her time keeping the appointment book, greeting patients, and performing such clerical and typing duties as her time may permit. Such positions are not common.

General Office Assistant—By far the largest number of physicians employ one girl whose duties are those of receptionist, typist, stenographer, bookkeeper, and clerk. She may or may not be required to perform simple laboratory procedures and to assist the physician in minor operations, examinations of patients, etc.

Technician—Many groups of physicians employ a competently trained technician who performs her duties much as does the staff in the laboratory of a hospital, but within the limits of the equipment available. Certain specialists or groups of specialists employ technicians

"Date With the Doctor"

Realizing the important role of the doctor's assistant in maintaining good public relations between the doctor and his patients, the Department of Public Relations of the Ohio State Medical Association has prepared an illustrated booklet containing some helpful hints for the doctor's receptionist as she meets his "publics."

Entitled "Date With the Doctor," the booklet suggests how patients in the doctor's office can be treated with consideration, tact and courtesy. Topics include: telephone manners; making appointments; handling correspondence; contacts with professional colleagues and community leaders.

A copy of the booklet was sent to members of the Association with the November OSMAGram. Additional copies may be obtained from the State Headquarters Office, 79 E. State St., Columbus 15.

trained and skilled in such procedures as the use of roentgenological equipment, etc.

Nurse—Surgeons and other specialists often find it necessary to employ Registered Nurses for assistance in the care of ambulatory patients.

Physiotherapist—A few specialists have need of trained physiotherapists (to be distinguished from limited practitioners who use that term) for rehabilitation work and other work of this type.

Most girls, not technically trained, enter employment of doctors after high school and occasionally college, usually also having had fundamental training in typing, stenography and bookkeeping—either in a commercial high school or in a private commercial or secretarial school. Many have had one or more years of experience in some business office.

In most cases, the doctor trains the new girl in urinalysis, making of blood counts, etc., and

uses her in a semi-technical capacity within the limits of her ability to absorb training and his ability to give it.

Technicians, physiotherapists and nurses, on the other hand, have specialized training and are secured through special channels.

TRAINING SCHOOLS

As to the new type of schools which have developed to train doctors' assistants, the report comments as follows:

"Within the past few decades, a new type of school has sprung up in this country offering training for 'Doctor's Assistants' or 'Medical Assistants.' Students in such schools are offered training in bookkeeping, typing, stenography, laboratory procedures, and the care of patients. They may or may not be offered beginning courses in physiology, bacteriology, etc. These are private schools, often operated by physicians or employing physicians and nurses as instructors. Some of these schools clothe their students in a uniform somewhat approximating the nurse's uniform. Many persons, including students and physicians solicited for employment, have indicated that they believed the graduates of such schools were trained technicians. No evidence is available to indicate that this training entitles them to such a belief.

"It is obvious that such schools come into existence in the hope that they will fill a need in the community and thus establish themselves on a firm and permanent basis. Such a hope is worthy and justifiable, even if a profit is intended, but providing a real need is filled and the practice of medicine helped.

"If this hope is realized, by adding to the usual commercial school education a preliminary course in the biological sciences and in simple laboratory procedures, then the commercial high schools and the private commercial schools might well consider the need for adding such courses. Indeed, one might question whether or not they are filling their place in the community if they do not offer such courses."

QUALIFICATIONS

Asked to list according to importance seven suggested qualifications of an assistant, physicians did so in the following order: (1) Office procedure, (2) typing, (3) stenography, (4) bookkeeping, (5) filing, (6) medical terminology and (7) laboratory procedures. The order would indicate to the authors of the report, not that laboratory procedures were less important than office procedures, but that the average physician: (a) Has adequate technical service, (b) sends his specimens to a recognized laboratory, or (c) will train the new girl himself.

A large majority of doctors answered that they would be willing to train an assistant in routine laboratory procedures. For 83 doctors who an-

swered that they would train such an assistant, only 18 said that they would not

The most commonly named laboratory procedures which physicians indicated they would expect an assistant to perform with the number of physicians indicating each are as follows: Urinalysis, 144; blood counts, 108; hemoglobin determination, 31; B. M. R., 19. Ninety-five physicians listed a scattering of 21 other procedures.

The wishes of physicians in regard to qualifications of an assistant were determined after screening 275 out of the answers received in response to the survey. Of 313 physicians who returned the questionnaire, 66 indicated that they were in general practice, 12 did not specify their type of practice, and the remainder indicated practice respectively in one of the specialties.

Oregon Medical Societies Cited in U. S. Antitrust Action

The Oregon State Medical Society and component sponsors of the prepaid medical care plan in that state in October have been named defendants in a civil suit filed by attorneys for the United States government charging them with violations of the Sherman Antitrust Law.

Named defendants in the suit, besides the Oregon State Medical Society, were the Oregon Physicians' Service, a corporation sponsored by the state society under which the prepaid medical, surgical and hospital care plan is administered; eight county societies; and eight individual doctors.

Specifically, the suit charges that "Beginning on or about January 1, 1936, and continuing thereafter up to and including the date of filing this complaint, the defendants have attempted to, and have been engaged in a combination and conspiracy to, restrain and monopolize interstate trade and commerce in the business of selling and furnishing prepaid medical care in the state of Oregon and in other states, in violation of Sections 1 and 2 of the Sherman Act (15 U.S.C., Sections 1 and 2)."

The suit charges the defendants have attempted: To monopolize prepaid medical care business; to limit the scope of medical care to be provided by prepaid medical care plans in the State of Oregon; to prevent, hinder, and obstruct prepaid medical care organizations other than those sponsored by defendants; to prevent doctors from cooperating in prepaid medical care plans not sponsored or approved by defendants; to restrict the use of hospital facilities by doctors cooperating in prepaid medical care plans other than those sponsored or approved by defendants; and to prevent Oregon hospitals from allowing their facilities to be used by doctors and patients associated with prepaid medical care plans other than those sponsored or approved by defendants.

Proceedings of The Council . . .

Blue Cross-Blue Shield Proposals Endorsed in Principle; Diabetes Educational Program, Without Detection Clinics, Is Given Approval

A SPECIAL meeting of The Council of the Ohio State Medical Association was held in the Columbus office on Sunday, November 14, 1948. In addition to The Council, Ohio delegates and alternates to the American Medical Association had been invited. Those who attended were: President Brindley, Past-President Rutledge, Treasurer Worstell; Councilors Swartz, Bowman, Mundy, Dixon, Davis, Swett, and Clodfelter; Delegates Schriver, Sherburne, Wisley, Wright, Woodhouse, and Skipp; Mr. Charles H. Coghlan and Mr. Frank Van Holt representing Ohio Medical Indemnity, Inc.; Mr. Charles S. Nelson, Executive Secretary; Mr. Hart F. Page, Assistant Director of Public Relations; and Mr. R. Gordon Moore, Assistant Managing Editor of *The Journal*.

On motion by Dr. Dixon, seconded by Dr. Davis, and carried, the minutes of the meetings of The Council held at Granville on September 17-19, 1948, were approved.

President Brindley announced that the main purpose for this special meeting was to consider proposals for the organization of a Blue Cross-Blue Shield Association and the organization of a Blue Cross-Blue Shield Health Service, Inc., which will come before the House of Delegates of the A. M. A. for consideration and action at the interim session of the A. M. A. in St. Louis, November 29-December 3.

At the request of President Brindley, Dr. Schriver, President of the National Blue Shield Association, analyzed and discussed both proposals, after which there was a question-and-answer period and a general discussion.

On motion by Dr. Clodfelter, seconded by Dr. Bowman, and carried, the proposal for the organization of a Blue Cross-Blue Shield Association was approved in principle without a dissenting vote and the Ohio delegates to the A. M. A. instructed accordingly.

On motion by Dr. Bowman, seconded by Dr. Worstell, and carried, the proposal for the organization of a Blue Cross-Blue Shield Health Service, Inc., was approved in principle without a dissenting vote and the Ohio delegates to the A. M. A. instructed accordingly.

At the request of the President, the Executive Secretary discussed the outcome of the recent November 2 election, so far as the make-up of the Ohio delegation to the new Congress and the new Ohio General Assembly is concerned. He also commented generally on the anticipated bills

which would be presented both to Congress and the State Legislature. A more complete report will be presented to The Council at its regular meeting in December, The Council was informed.

Several communications regarding the educational program of the National Diabetes Association and new literature from that Association regarding this program were read and discussed. On motion by Dr. Swartz, seconded by Dr. Davis, and carried, The Council adopted the following statement of policy, supplementing the action on this matter taken by The Council at its meetings at Granville, September 17-19.

"That the Ohio State Medical Association approves the proposed program of the National Diabetes Association to educate the public and the medical profession on various phases of diabetes and its control; but that the Association does not approve at this time a proposal by that Association for establishing so-called detection centers or clinics, it being the sense of The Council that such matters should be handled by the physician in private practice in his own office or in established hospitals."

There being no further business, The Council adjourned to meet on Sunday, December 12, 9:30 a. m., in the Columbus office.

Attest: CHARLES S. NELSON,
Executive Secretary.

Cuyahoga Academy Health Lectures

A series of Sunday afternoon health lectures, free to the public, is being sponsored by the Academy of Medicine of Cleveland, through its Health Education Foundation, established by the Academy in the interest of better health for the citizens of Cuyahoga County.

The first of the series was held on November 28 with Dr. H. V. Paryzek and Dr. Farrell T. Gallagher, of Cleveland, speaking respectively on "Medical Emergencies" and "Surgical Emergencies."

The second lecture is scheduled for December 5 with Dr. Elliott Joslin, Boston, speaking on "Diabetes Yesterday, Today and Tomorrow."

The third will be held on January 30 with Dr. Roy W. Scott and Dr. Claude S. Beck, of Cleveland, speaking respectively on "Medical Aspects of Heart Disease" and "Surgical Aspects of Heart Disease."

Postgraduate Seminars . . .

Three Courses Sponsored by Association at Chillicothe, Lima and Mansfield Emphasize Practical Side of Diagnosis and Treatment

THE practical programs presented at the three postgraduate seminars sponsored by the Committee on Education of the Ohio State Medical Association at Chillicothe, October 21, Lima, October 27, and Mansfield, November 3, were generally well received by the approximately 360 physicians who attended one or more of them. Following the committee's instructions the speakers emphasized diagnosis and treatment, passing on to their listeners helpful advice of practical use in everyday practice. Panel discussions and question-and-answer periods added to the teaching value of the presentations.

"Newer Advances in the Diagnosis and Treatment of Chest Diseases," was the subject presented at the Chillicothe meeting, which was held at the Elks Home. Dr. Carl A. Wilzbach, health commissioner of Cincinnati, and chairman of the Association's Committee on Education, presided. Dr. John H. Skavlem, Cincinnati, medical director of the Hamilton County Tuberculosis Sanatorium, acted as moderator and was one of the speakers. Other speakers were: Dr. W. L.

Potts, Columbus, tuberculosis controller for Columbus and Franklin County; Dr. D. W. Heu-sinkveld, instructor in medicine, Division of Tuberculosis, University of Cincinnati College of Medicine; Dr. Joseph B. Stocklen, Cleveland, controller of tuberculosis for Cuyahoga County; Dr. Maurice G. Buckles, Columbus, assistant clinical professor of thoracic surgery, Ohio State University College of Medicine; Dr. Sidney E. Wolpaw, Cleveland, assistant department head at the Tuberculosis Division of Cleveland City Hospital; Dr. Arnold B. Kurlander, Chief, Division of Tuberculosis, Ohio Department of Health.

Local arrangements for the meeting were in charge of: Dr. M. D. Scholl, chairman; Dr. Walter E. Kramer, Dr. Loy E. Hoyt, and Dr. H. M. Crumley.

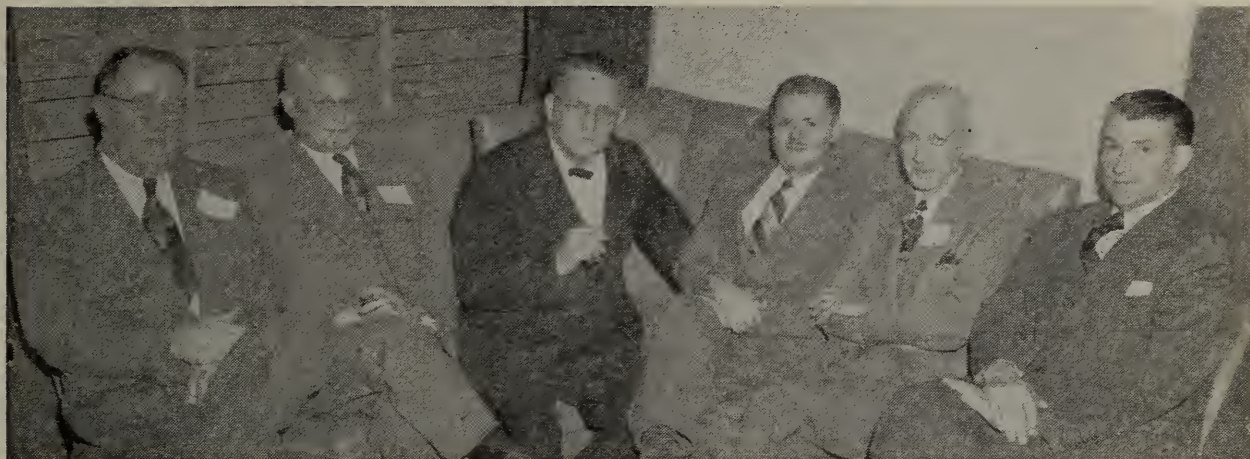
"Practical Cardiology," was the topic discussed at the seminar held in the American Legion Hall, Lima. The Committee on Education was represented at this session by Dr. Edwin P. Jordan, Cleveland, who presided. The speakers were: Dr. A. Carlton Ernstene, director of the

Photo of Audience at Mansfield Seminar



This audience of physicians photographed at Mansfield is typical of groups which attended the Association's three postgraduate courses at Chillicothe, Lima and Mansfield, respectively.

Reception Committee at Mansfield Postgraduate Seminar



Members of the Richland County Medical Society who acted as a reception committee at the Mansfield Postgraduate Course, left to right, are: Dr. W. H. Buker, Dr. J. S. Hattery, Eleventh District Councilor; Dr. R. V. Myers; Dr. Paul A. Blackstone, president of the Society; Dr. W. E. Wygant, chairman of the committee on arrangements, and Dr. W. M. Brown.

Department of Medicine, Cleveland Clinic; Dr. Harold Feil, clinical professor of medicine, Western Reserve University School of Medicine; Dr. Robert D. Taylor, staff member, Division of Research, Cleveland Clinic.

The local committee on arrangements consisted of: Dr. H. G. Deerhake, chairman, and Dr. Robert M. Johnson.

"Practical Dermatology," was the general subject for the Mansfield session, held in the Mansfield-Leland Hotel. Dr. Thomas E. Rardin, Columbus, a member of the Committee on Edu-

Wisc., professor and head of the Department of Dermatology and Syphilology, University of Wisconsin School of Medicine.

Local arrangements for the meeting were in charge of the following: Dr. W. E. Wygant, chairman; Dr. R. V. Myers, Dr. Wallace H. Buker, and Dr. John Horst.

The Committee on Education expresses appreciation to the officers of the Ross, Allen, and Richland County Medical Societies and to the local committees for their services as hosts and for seeing that proper facilities were provided for the meetings.

A meeting of the Committee will be held soon to formulate plans for the Association's postgraduate program in the future. Reactions to the recent series will be discussed. Comments and suggestions will be welcomed by members of the Committee.



Guest speakers at the seminar on "Practical Dermatology" are shown discussing with the general chairman phases of the course. Left to right are: Dr. Thomas E. Rardin, Columbus, member of the Association's Committee on Education; Dr. Arthur C. Curtis, Ann Arbor, Mich.; Dr. Sture A. M. Johnson, Madison, Wisc.; and Dr. Edward P. Cawley, Ann Arbor, Mich.

cation, presided. Dr. Arthur C. Curtis, Ann Arbor, Mich., professor and chairman of the Department of Dermatology and Syphilology, University of Michigan Medical School, was moderator and one of the speakers. Others on the program were: Dr. Edward P. Cawley, Ann Arbor, assistant professor of dermatology and syphilology at the University of Michigan Medical School, and Dr. Sture A. M. Johnson, Madison,

Toledo Medical Library Loan Service

An additional library on the list of those from which physicians may borrow medical books and periodicals is the Toledo Medical Library Association, Toledo. Information on the facilities of this library was sent to the Association Headquarters after a news article appeared in the August issue of *The Journal* listing a number of libraries throughout the state offering such service to physicians.

Books and journals, with few exceptions, are loaned for periods of two weeks. In exceptional cases the library will mail material, but the librarian, Miss Virginia Donley, prefers to arrange lending service through another medical or public library.

The library has a collection of approximately 12,000 volumes, including 3,000 bound journals. Comparatively few of the books are of recent publication.

Division of Nursing . . .

Consultant, Advisory and Training Service Furnished by Ohio
Department of Health to Local Health Units Throughout State

THE Division of Nursing of the Ohio Department of Health dates to 1913 when the Bureau of Public Health Nursing was created. It became a division in 1923.

Its functions may be summarized as: (1) A consultant and advisory nursing service to the director of health, and other divisions within the Department on matters pertaining to nursing; and (2) a consultant nursing service available to all city and general district health departments, boards of education and non-official agencies throughout the state on public health nursing standards, procedures and techniques. Its services consist of reports, compiling of manuals on public health nursing, furnishing information on nursing qualifications, activities and techniques.

Field services consist of: (1) Conferences with health commissioners and nurses in official agencies and in allied agencies; (2) field visits and agency visits to assist in evaluating the nurse's work and the analysis of their activities including record keeping; (3) demonstrating of nursing techniques; (4) planning of progressive educational procedures for nurses by institutes; (5) staff conferences; and (6) post-graduate preparation and reading material.

An up-to-date tabulation of all public health nursing agencies and nursing personnel throughout the state is kept at all times as well as a list of public health nurses whose applications and credentials can be recommended to health agencies seeking nursing personnel.

STAFF

The Division staff at present consists of a chief, an assistant chief, six specialized nursing consultants, four generalized nursing consultants and a clerical staff of three members. Respective specialties of the six consultants are in the fields of cancer, venereal disease, tuberculosis, pediatrics, hospital inspection and construction, and school health.

Chief of the Division is Miss S. Gertrude Bush, who has been with the Department since 1936. She is a graduate of Chester County Hospital, Pennsylvania, and took postgraduate work in public health nursing at Western Reserve University. Other interests of Miss Bush include memberships in the Altrusa Woman's Club and the Booklovers Club of Columbus.

An Educational Nursing Advisory Committee,

This is another in a series of articles on the organization, functions, and programs of the Ohio Department of Health and its subdivisions, under Dr. John D. Porterfield, director. Previous articles included summaries on the reorganization of the Department, the Cancer Division, Child Hygiene Division, Vital Statistics Division, the Tuberculosis Division, and the Hospital Facilities Office.

consisting of 14 outstanding nursing leaders in Ohio, was appointed by the director of health in 1940.

NURSES IN STATE

The number of public health nurses in the state during the last six years has averaged 1,100 per year for a population of approximately 7,000,000. In January of 1944 there was one nurse to 6,500 urban population, and one nurse to 8,080 rural population. If national standards of one nurse to 5,000 population were to be considered, Ohio would need an additional 400 nurses in the field of public health, Department officials declared.

In the last six years there have been an average of 20 nurses per year receiving assistance in the preparation for public health nursing. Four local county health units serve as teaching centers for universities where nurses observe and participate as a part of their preparation in the field of public health. The Division supervises and keeps up-to-date outlines of procedures for these units and assists in securing properly prepared nursing personnel as teachers. In addition to the university students studying in these fields, many public health nurses have been placed in these units for one year of supervised field experience.

PERSONNEL TURNOVER

The Division has about 160 nurses on its payroll, most of whom serve in local communities. In spite of the fact that the Department assisted in filling 73 vacancies last year, there is still an alarming shortage of personnel to fill vacancies. Continual loss of nursing personnel is a harrying problem for the administrative staff, who reported a current annual turnover of 37 per cent.

The training program for new personnel monopolizes considerable time of the consultant service. Orientation and in-service education

for beginning public health nurses, and refresher courses for older nurses, save consultant time in the introduction of new staff members.

Health units participating in the training program are those in Cuyahoga, Greene, Lucas, Wood, Marion, Portage, Logan, Wayne, Madison, and Lorain counties.

Scholarships covering 81 months of accredited study in the fields of premature care, pediatrics, obstetrics, school health service and general public health were given 24 nurses from training funds.

Educational staff conferences on the local level have been gratifying, officials reported. Sixty-nine such conferences were held last year, many of them including nurses for two or more adjoining counties. These conferences are largely educational, bringing nurses up to date on new subjects or old subjects with new emphasis.

SERVICES DISTRIBUTED

To better distribute consultant services, specialized nursing consultants have been placed in district offices at Toledo, Dayton and Canton as well as in the central office in Columbus. By this means travel time is much less than when they worked out of the central office only. During the year 1947, 358 conferences were held with health commissioners, usually on nurse service, but frequently on the subject of general health organization.

The "Count and Qualifications of Public Health and Industrial Nurses" was tabulated for a report to the U. S. Public Health Service. According to this report there were 1,057 public health nurses in 271 agencies, and 570 industrial nurses in 192 industries. Since 1940 the Division has kept a roster of industrial nurses with records of where they are employed.

PUBLICATIONS

Since 1939 the Division has prepared for distribution bulletins on the following subjects: "Organization of Classes for Prospective Mothers"; "Organization of a Venereal Disease Clinic"; "The Guide for Public Health Nurses" (revised); "The Guide for Supervising Nurses"; and "The Immature Infant and His Nursing Care."

An exhibit of a miniature home for maternity delivery was built and equipped and used as a demonstration in conjunction with classes for prospective mothers. Outlines of procedures for field experience in the training of nurses for public health nursing have been compiled and revised to meet nursing needs.

A special project last year was the organization of a training center for field training of all public health personnel. Lorain County was chosen as a center. Funds from the State Department through Federal grant-in-aid and from the Kellogg Foundation made possible this center.

A second project of equal interest was the

establishment of a training center for hospital nurses in the specialty of premature infant care. A supplementary course in the care of premature babies was established at Children's Hospital, Columbus. One field nursing consultant with training in pediatrics and premature care is loaned to this project.

The staff assists in serving on a number of state and local committees, including: Ohio Society for Crippled Children's Cerebral Palsy and Epileptic committees; Women's Activity Committees of the Ohio State Safety Council; Ohio Nurses Association Committee on School Health Service; Committee on Mental Hygiene and Bureau of Local Nursing Service; the League of Nursing Education Program Committee; Committee for Sponsoring the Community Health Education Project; and a subcommittee of the group to study child welfare service in Ohio.

The 1949 budget of the Division of Nursing is \$67,551, of which 18.3 per cent is paid out of state funds, and the remainder out of Federal grant-in-aid funds.

New Members of O. S. M. A.

Following are the names of new members of the Ohio State Medical Association, since October 5, 1948. The list shows the county in which they are affiliated, city in which they are practicing, or temporary addresses in cases where physicians are taking postgraduate work.

ATHENS COUNTY

John P. Greenlees, Gloucester
J. L. Wheaton, Nelsonville

CUYAHOGA COUNTY

Angela B. Adams, Cleveland
John D. Battle, Jr., Cleveland
Edward E. Bauman, Cleveland
Charles H. Brown, Cleveland
Joseph E. Brown, Cleveland
Robert R. Cadmus, Cleveland
Paul G. Cressman, Jr., Cleveland
Edward B. Depp, Jr., Cleveland
Robert M. Eiben, Cleveland
Frank S. Houser, Cleveland
Thorpe A. Klumph, Jr., Cleveland
Boris L. Marmolya, Cleveland
James L. Orbison, Cleveland
Mildred H. Shelly, Cleveland
Eugene J. Weber, Cleveland

FRANKLIN COUNTY

Harold V. Beighley, Columbus
James B. Campbell, Columbus
John H. Holzaepfel, Columbus

James H. McCreary, Columbus
David W. Palmer, Columbus

HAMILTON COUNTY

William H. L. Dornette, Chandler, Arizona
Robert A. Helm, Cincinnati
Carl Wehl, Cincinnati

JEFFERSON COUNTY

Jacob Mervis, Steubenville

MADISON COUNTY

Ernest S. Crouch, London

MIAMI COUNTY

Richard H. Wehr, Syracuse, New York

MONTGOMERY COUNTY

Arnold Allen, Dayton
Robert E. Hancock, Dayton
Edwin G. Olmstead, Dayton
Edgar J. Reagan, Miamisburg
William A. Stowe, Dayton
Arthur L. Ventura, Dayton
Kenneth A. Welty, Vandalia

RICHLAND COUNTY

Paul J. Lee, Lucas

STARK COUNTY

Jack G. Hendershot, North Canton

WILLIAMS COUNTY

Irving L. Colvin, Edon

Probe of Kick-Backs and Frauds . . .

Cleveland Academy of Medicine and Better Business Bureau Join in Attack On Unethical Doctors and Merchants, Fraudulent Advertising, Etc.

AN all-out attack on unethical and fraudulent practices on the part of physicians, other classes of practitioners, and firms which supply them with materials and appliances is being made by the Cleveland Academy of Medicine and the Cleveland Better Business Bureau.

This joint effort resulted from a study made by a special committee of the Academy of Medicine and subsequent conferences with officials of the Better Business Bureau. A financial contribution to get the program under way has been made by the Academy.

The reasons for the investigation, its scope and how it will be carried out are described in a communication sent to all members of the Academy of Medicine by its president, Dr. D. A. Chambers, and Dr. H. B. Wright, chairman of the Committee on Public Policy and Legislation, which read as follows:

TEXT OF LETTER TO MEMBERS

"Rarely has there been a time when the medical profession has been threatened by so many forces of disintegration as the present. The most potent weapon against such ideas as the socialization of medicine or other radical and impracticable innovations has been and will continue to be, the feeling of respect and confidence which the public has for its physicians. It would seem obvious that the greatest service your medical organization can perform for its members is to be active in protecting the good name of the profession.

"One of the greatest blows to the prestige of the medical profession came when wide publicity was given to the fact that some eye doctors have been accepting monetary rebates or other 'kick-backs' from the retail dispensers of eyeglasses. Articles in the *Reader's Digest* and the *American Weekly* (Sunday newspaper supplement) have been widely read and have created considerable resentment and distrust towards the profession. The civil legal action taken by the government against two large optical manufacturing concerns and a large number of ophthalmologists has provided a background of authenticity which cannot be deprecated.

ASKED B. B. B. FOR ADVICE

"The committee appointed by the President of the Academy of Medicine to investigate the situation, became convinced that this and several other types of unethical practices exist in this county. They recommended that definite action

be taken by the Academy to the end of renewing public confidence in the medical profession. The question then arose concerning which method of correction to employ. After careful consideration of all the factors involved, it was decided to call upon the Cleveland Better Business Bureau for advice.

"The Better Business Bureau conducted its own investigations, became convinced that a damaging situation exists, and voiced the opinion that their Bureau possessed the methods and the experience to efficiently correct the evils. It is certainly true that their methods of controlling and maintaining honest business practices in this community have been eminently successful.

SIX CONDITIONS TO BE CHECKED

"The Academy Directors and the Bureau agreed that the following types of unethical practices were to be corrected:

- "1. Fraudulent medical advertising.
- "2. Rebating to physicians from the sale of eyeglasses.
- "3. Rebating from the sale of diagnostic and therapeutic mechanical apparatus.
- "4. The control of unlicensed and limited licensed practitioners who overstep the bounds of their legal limitations.
- "5. The practice by certain druggists of giving physicians rebates from remedies sold to patients.
- "6. The activities of some physicians who falsely promise impossible cures and fraudulently treat incurable diseases.

"It was felt that the first three items listed above should receive the initial concentrated effort.

FINANCIAL AID GIVEN

"Your Board of Directors was so strongly impressed with the need for action that they granted the Better Business Bureau the sum of two thousand five hundred dollars with which to start the campaign. This sum will last only a few months, so the further continuance of the effort will necessitate additional funds. Professional membership in the Better Business Bureau will be offered each member of the Academy of Medicine. The best evidence of your cooperation toward the whole project will be your acceptance of one of these professional memberships.

"We wish to draw your attention to the fact that this campaign is not one of vindictiveness.

It does not seek to punish those who have erred in the past. It only seeks to correct and maintain the correction of a currently existing evil. Should all of the offenders stop their objectionable practices immediately, no further step would be necessary except that of competent inspection to make sure that there is no backsliding.

THE FIRST STEP

"You will also note that the campaign is to be carried out initially against the unethical retail dispenser of eyeglasses; the promoter of false medical advertising; and the unethical retailer of medical apparatus. This is similar to the direction taken by the government in its current legal actions. The government admits that, while the doctors cited are believed to be guilty, the doctors did not think up this proposition themselves, but were led into it by commercial firms.

"It is the opinion of your Board of Directors that action to correct the situation in Cuyahoga County is necessary, that its successful conclusion will create renewed confidence in the medical profession and they hope you will support the campaign in every possible way."

Rheumatic Diseases Congress

The seventh International Congress on Rheumatic Diseases will be held in New York City, May 30 through June 3, 1949, under sponsorship of the International League against Rheumatism. Hosts will be the officers and 400 members of the American Rheumatism Association, assisted by The New York Rheumatism Association. Secretary of the American Rheumatism Association is Dr. Charles Ragan, Presbyterian Hospital, New York 32.

Public Health Grants

Four grants amounting to \$68,509 for research in medical and related scientific fields were placed in Ohio by the U. S. Public Health Service. The four were among 37 placed by the service amounting to \$455,715.

The grants, within the fields indicated, were as follows: Ohio State University College of Medicine, "Etiologic studies in the lymphogranulomata and related diseases," \$2,000; Ohio State University, "Use of radioactive isotopes to trace organic compounds of biological significance," \$14,875; Western Reserve University, "Revascularization of the heart," \$27,884; and Cleveland Clinic Foundation, "Arteriosclerosis—aging and other factors," \$23,750.

Dr. Fred T. Foard has been appointed director of health of the Bureau of Indian Affairs in the Department of Interior.

Kent Conference of Ohio Rural Health Council Draws 115

The first in a series of district conferences sponsored this fall and winter by the Ohio Rural Health Council, was held October 30 at Kent State University, Kent.

The program of the Kent conference, with an attendance of 115 persons from 21 counties, was devoted exclusively to a discussion of local and state public health needs.

The conference was addressed by Dr. John D. Porterfield, State Director of Health; Dr. Harry Wain, Mansfield, Richland County Health Commissioner; and Dr. Marion G. Fisher, Health Commissioner of Oberlin, Ohio. Miss Florence M. Hellman, Kent State University Health Coordinator, summarized the conference.

After the talks of the three speakers, the conference was divided into six discussion groups to consider various problems, including more adequate funds for the operation of the State Department of Health; more local community responsibility for the support of local health departments; consolidation of certain local health departments; need for full-time health commissioners and more adequate services by local health units; and increased health education activities.

Physicians registered included: Dr. Paul A. Davis, Akron, Sixth District Councilor of the Ohio State Medical Association; Dr. Fred W. Dixon, Cleveland, Fourth District Councilor; Dr. Fisher; Dr. J. A. Haney, Steubenville, Chairman, Committee on Rural Health, Jefferson County Medical Society; Dr. P. L. Harris, Canton, Stark County Health Commissioner; Dr. E. G. Kyle, Newton Falls, President, Trumbull County Medical Society; Dr. E. W. List, Bristolville, Committee on Rural Health, Trumbull County Medical Society; Dr. G. A. Lucas, Akron, Committee on Rural Health, Summit County Medical Society; Dr. T. F. McGough, New Philadelphia, Tuscarawas County Health Commissioner; Dr. Paul Q. Peterson, State Department of Health; Dr. Porterfield, and Dr. Wain. Mr. Hart F. Page, Secretary to the Committee on Rural Health of the Ohio State Medical Association, participated in the conference as a group leader. The physicians present took an active part in the group discussions.

Additional district conferences have been scheduled as follows: Southwest District, at Wilmington, December 3; Northwest District, Bowling Green, February 2; and Southeast District, Athens, February 8.

The annual state-wide conference will be held in Columbus, February 28-March 1, 1949, while the Fourth Annual National Conference on Rural Health is scheduled for February 4 and 5, in Chicago.

Woman's Auxiliary . . .

Columbus Academy Ladies Are Hostesses as State, District and Other Auxiliary Officers Convene for Annual Fall Board Meeting

THE Annual Fall Board Meeting and Conference of Presidents, Presidents-Elect, Officers and Chairmen of State Committees of the Woman's Auxiliary to the Ohio State Medical Association was held at the Seneca Hotel in Columbus on October 18 and 19. The Woman's Auxiliary to the Columbus Academy of Medicine was hostess to the visiting ladies.

Among those present were the following state officers: Mrs. E. B. Gillette, Toledo, state president; Mrs. C. W. Kirkland, Bellaire, president-elect; Mrs. George W. Cooperrider, Columbus, state vice-president; Mrs. C. H. Bell, Mansfield, secretary; Mrs. Wilbur A. Taylor, Toledo, recording secretary; Mrs. Robert Kotte, Cincinnati, treasurer; Mrs. Paul A. Davis, Akron, past president; Mrs. John L. Stevens, Mansfield, advisor from the national auxiliary.

The following district directors were present: Mrs. E. P. Greenawalt, Springfield, Second District; Mrs. Karl Ritter, Lima, Third District; Mrs. Cyrus Wood, Port Clinton, Fourth District; Mrs. Chester Swett, Lancaster, Eighth District;

Mrs. S. L. Meltzer, Portsmouth, Ninth District; and Mrs. W. W. Peirce, Mansfield, Eleventh District.

The program included a panel discussion on the subject, "The Role the Doctor's Wife Plays in the Community." Mrs. George I. Nelson, Columbus, acted as moderator. Taking part in the panel were Dr. Allan C. Barnes and H. Gordon Hullfish, Ph. D., both of Ohio State University; Miss Genevieve Taylor, chief probation officer and referee, Franklin County Court of Domestic Relations, and Mrs. Ralph W. Hoffman, executive secretary, Metropolitan Health Council.

Dr. Charles A. Doan, dean, Ohio State University College of Medicine, and Mr. Charles S. Nelson, executive secretary of the Ohio State Medical Association, were principal speakers at the Tuesday luncheon.

Arrangements were in charge of Mrs. Donald Alspaugh, Columbus, chairman of the state convention committee, and Mrs. Wayne Brehm, also of Columbus, co-chairman.

Auxiliary Board Luncheon at Seneca Hotel



At the speakers' table were the following persons (some of whom are obscured by decorations in the above photo): Mrs. C. N. Bell, state secretary; Mrs. Wilbur Taylor, state corresponding secretary; Mrs. George Cooperrider, state vice-president; Dr. E. Benjamin Gillette of Toledo and Mrs. Gillette, state president; Mr. Charles S. Nelson, executive secretary of the Ohio State Medical Association; Mrs. C. W. Kirkland, state president-elect; and Mrs. Robert H. Kotte, state treasurer.

Auxiliary State and District Officers at Convention



Seated left to right are: Mrs. George W. Cooperrider, Columbus, state vice-president; Mrs. E. Benjamin Gillette, Toledo, state president; Mrs. C. W. Kirkland, Bellaire, state president-elect, and Mrs. John L. Stevens, Mansfield, advisor from National Auxiliary and past-president. Standing are: Mrs. Wilbur A. Taylor, Toledo, state corresponding secretary; Mrs. Robert H. Kotte, Cincinnati, state treasurer; Mrs. S. L. Meltzer, Portsmouth, director Ninth District; Mrs. W. W. Peirce, Mansfield, director Eleventh District; Mrs. Chester Swett, Lancaster, director Eighth District; Mrs. Cyrus Wood, Port Clinton, director Fourth District; Mrs. Karl Ritter, Lima, director Third District; Mrs. E. P. Greenawalt, Springfield, director Second District; and Mrs. C. H. Bell, Mansfield, state secretary.

ROUNDUP ON PREPAID MEDICAL CARE PLANS

Female subscribers cost Blue Shield Plans approximately three times as much for surgical benefits as do male subscribers, while female dependents are only slightly less costly by comparison. Obstetrical and gynecological costs account for most of this difference.

Peculiarly, the female subscriber and female minor dependent have a high rate of utilization for appendectomies, while the female spouse has a lower than average utilization for the same service.

Female costs in the field of general surgery are above average, due principally to breast tumors.

Male dependents, chiefly minors, are more costly than female dependents of the same age, because of services such as herniotomies, circumcisions, fractures and dislocations. Boys seem

to suffer exactly twice the number of broken bones as do girls.

* * *

The number of persons covered under Ohio Medical Indemnity, Inc., (Ohio Doctors' Plan) contracts as of October 31, was 428,683, an increase of 11,909 for the month.

* * *

Medical Service Association of Pennsylvania has completed the repayment of nearly \$100,000 advanced to its credit by the sponsoring state medical society.

The Medical Society of the State of Pennsylvania had loaned Blue Shield \$71,000 in cash and \$24,700 in bonds to enable the Plan to meet its minimum legal reserve and initial operating expenses at the time of organization in 1940.

Unusual difficulties were encountered by Blue Shield in Pennsylvania during its early years, but recently completed agreements with several Blue Cross Plans in the state have stepped up enrollment. During the second quarter of 1948, Pennsylvania's Blue Shield Plan experienced better than a 50 per cent enrollment increase, growing from 150,001 to 227,172 members.

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT MR. FARMER THINKS AND SAYS WILL BE IMPORTANT

The political analysts are pretty well agreed that the so-called farm vote played a vital part in the Truman election. If that is true, then it may be assumed that rural folk will be consulted during the next four years on policies pertaining to many important public issues, such as medical care and public health programs. Wouldn't it be well, therefore, for the medical profession to strengthen its relations with the rural people of Ohio?

Fortunately, through the efforts of the Committee on Rural Health of the Ohio State Medical Association a spirit of cooperation and mutual confidence has been developed between the officials of the Association and of the leading farm organizations of the state. Unfortunately, this is not the situation in some local areas.

Those county medical societies who have been slow—too slow—in setting up a committee to work with the farm people on health questions and in giving them the advice and guidance which they need and have requested, had better get busy.

Now is the time to prove to the farmer, through actions, not just words, that his medical and health problems can be met without resorting to fancy programs which in the end won't give him as much or as good as he is now getting, and will cost him considerably more, to boot.

CHANGES IN GOVERNORSHIP AND PUBLIC HEALTH

When Frank Lausche returns to the governorship this coming January, changes will take place in some of the executive departments of the state government. That always happens when a new governor takes over, especially when the new governor and his predecessor are of different political faiths. It may not enhance the efficiency of certain departments but it is done, nevertheless.

Fortunately, there will be no change in the Ohio Department of Health where Dr. John D. Porterfield, the director, is doing a splendid job and sponsoring a well-rounded program. The director of health is appointed for a five-year term. Porterfield's has several years to run. Because of this provision, there can be continuity and stability to the activities of the health department.

Those who realize the value of this situation can thank the Ohio State Medical Association

and the Ohio Tuberculosis and Health Association for making it possible. Those organizations were the ones who led the fight a decade ago to have the law changed to provide for a five-year term for the director of health. The wisdom of the Legislature in approving the measure sponsored by the two groups is now paying dividends.

During the past two years, some definite progress has been made in public health administration in Ohio. Because of the official and personal interest taken by Governor Herbert, public health activities in the state registered new gains. Although certain goals were not reached, Mr. Herbert will leave a good record on medical and health affairs when he turns over his office to his successor.

Governor-elect Lausche will be among the first to realize that much remains to be done, we are confident. During his administration in 1945-46, he, too, took an active interest in building up Ohio's health program. Doubtless he will want additional achievements consummated. It is hoped that one of the first things he will tackle will be to do everything within his power to improve the financial structure of the Ohio Department of Health and insist that the Legislature in which there will be a majority who are members of his own political party, take whatever steps will be necessary to accomplish this.

SOME DOCTORS FAILED TO SEE THE WOODS BECAUSE OF THE TREES

Through the grapevine comes word that the medical profession in some Ohio cities made a mighty poor showing in the Community Fund campaign in their cities. Obviously criticism should not be directed at the profession as a whole. No doubt many physicians gave as much—or more—as in past years. But it's the old story of the group being blamed for the actions of some of the group.

The physicians who failed to meet their responsibility by refusing to help the Community Fund, especially in 1948 A. D., were not only shortsighted but downright ignorant of present-day trends. They missed a fine opportunity to aid a worthy cause; to support a voluntary program at a time when many, especially the medical profession, are greatly concerned about government controls, too much government, government dictation, etc.

Moreover, they missed the boat when it comes to improving the public relations of the medical profession. Only the blind will say that it doesn't need improving. It is difficult to under-

stand how any physician can think in these days that he can remain aloof from community enterprises such as the Community Fund. If the medical profession ever needed the good will and support of the public, especially of community leaders, it is now.

Those who failed to meet their obligations in the Community Fund drive in their communities will regret their negligence. Unfortunately, the entire medical profession will be blamed for their attitude—something which the medical profession can't afford at any time, especially now, when the profession is having a hard enough battle to maintain the confidence and respect of the man on the street.

G. I. STUDY OF MEDICINE IN EUROPE PROTESTED

Indication on the part of the Veterans Administration that it will approve certain European medical schools so that ex-veterans can enroll in them for training under the G. I. Bill of Rights has brought forth a strong protest from the *New England Journal of Medicine*.

That magazine points out that European standards of medical education have been on the down grade for quite some time and that the V. A. should not encourage our former servicemen to go out after an "ersatz sheepskin."

With this we agree. The difficulties which most of the states have had on matters of licensure involving graduates of European medical schools is well known. About the only thing which can possibly result if the V. A. goes through with this ruling is more confusion and more grief for everybody, including the G. I.'s participating.

BENCH-WARMERS NEVER WIN THE GAME

If there are physicians in Ohio who are not gleeful over the outcome of the recent election (there probably are a few), it would be well for them to quit weeping over what they may consider a spilled election. They should take cognizance of its lessons, and profit thereby.

After all the apparent causes, alibis and excuses have been digested, there remains but one outstanding reason why President Truman was returned to the White House: Because certain individuals and groups who felt that the kind of an administration which he had promised for the next four years would be to their liking worked harder for his election and went to the polls in greater numbers than those who favored Mr. Dewey.

One statistician has pointed out that two more Dewey votes in each of Ohio's 9,000—odd polling places would have given the New Yorker the Buckeye State, and if that had happened in a

few other key states, the entire election would have been different.

There is no way of knowing (even if we wanted to know) what part the medical profession played in the recent campaign and election. Nevertheless, this much is true: The margin of votes which Ohio gave to Mr. Truman is probably less than just the number of votes controlled by members of the medical profession in Ohio and the voting members of their families. All of which shows that in close contests, the votes which can be swung by physicians, their families and acquaintances can well be a vital factor in the final outcomes.

Another point which seems perfectly obvious is that those who want something, such as the election of a certain candidate or the passage (or defeat) of a certain issue, are not going to get any place by warming the bench. Those who worked for Mr. Truman (and don't think this wasn't done) and those who wanted him elected took the slant that anything worth wanting is worth going after in a big way. So they rang doorbells and voted. A lot of lazy folk who disagreed with them, didn't. It's a point worth filing away for future reference.

THERE'S ONLY ONE SIDE, SAYS THE POST

Our hat's off to the *Saturday Evening Post*!

An antivivisection letter writer, irate over the *Post's* article, "They're Trifling With Your Life," in which medical research was defended, has asked the editors: "Are you going to print the other side of the vivisection question?" To which the *Post* replied: "We made an exhaustive study of the pros and cons of vivisection before we published 'They're Trifling With Your Life.' Not one valid argument in support of the anti-vivisectionist viewpoint was found."

It's about time for more magazines of similar prominence (we won't name names) to get out of the habit of publishing exaggerated and inaccurate pieces on medical and health subjects in order to build circulation. The public is being fed enough bunk by the low-grade sheets.

LAXITY IN REPORTING CASES OF SYPHILIS IN OHIO

According to the Division of Venereal Diseases, Ohio Department of Health, the number of cases of early syphilis reported in 1947 was about 6,000 less than the number reported in 1946. The greatest percentage of decrease was among private physicians. Actually, cases reported by physicians decreased 55 per cent; cases reported by clinics, 18 per cent.

On the face of it, this would seem to indicate that great strides have been made in Ohio in

the fight on syphilis. But, the figures are misleading in the opinion of health officials.

Naturally, the widespread use of penicillin and the establishment of rapid treatment centers have had considerable influence. However, the fact that the number of cases reported by physicians has declined so much more than cases reported by clinics has led officials to feel that some physicians are becoming lax in reporting cases to the health departments.

This is not good. Improvements in the syphilis control and treatment programs cannot be made nor venereal diseases reduced to a bare minimum unless there is complete reporting by both physicians and clinics. This may seem like a comparatively trivial thing to some physicians—even a bother—but they should remember that experience and statistics are indispensable in programs of this type.

IT'S A GOOD IDEA PROVIDING . . .

Commenting on cancer diagnostic facilities and detection centers, *The Journal of the A.M.A.* recently pointed out that it will be impossible to establish enough cancer detection clinics to handle 142,000,000 and that facilities will have little meaning unless manned by interested, alert and qualified physicians. It suggests the slogan: "Every Physician's Office a Detection Center."

Obviously, the idea is sound. It's the way medicine should be practiced, not on a mass-production, assembly-line basis. Nevertheless, slogans, without action, won't do the job.

The action has to be supplied by "each physician" who must prepare himself to make acceptable diagnostic examinations and must be willing to provide them at his patients' request. Experience has shown that some physicians do not make a competent examination either because they are unable or unwilling; that others give the brush-off to patients seeking one.

YOU CAN'T PASS THE BUCK WHEN NEGLIGENT

Can an operating surgeon and a hospital wherein the operation was performed be sued as joint tort-feasors for their alleged separate negligence in postoperative care of the patient?

Yes, said the Court of Appeals of Hamilton County in the case of Blanton, Admr., appellant, v. Sisters of Charity, D.B.A. Good Samaritan Hospital, et al., appellee, which was remanded recently for further proceedings in the Common Pleas Court.

The syllabus of the court's decision, which contains a warning to all physicians, is as follows:

1. An operating surgeon and the hospital

wherein the patient is operated each sustain a relationship to the patient giving rise to a duty of care running directly to each participant in the common enterprise, for the violation or neglect of which, resulting in injury to the patient, a primary liability is created on the part of each, which neither could escape by showing the other to be also guilty of a wrong.

2. Where a petition alleges that an operating surgeon and a hospital, wherein the operation was performed, by their separate acts of negligence in postoperative care, permitted the patient, a minor child, to bleed to death following a tonsillectomy, and specifies the acts of negligence of both, alleging that the concurrent acts of negligence of both directly caused an indivisible injury to the patient, the doctor and the hospital may properly be joined as defendants in a suit for damages or wrongful death occasioned by such negligence.

SUGGESTS CLOSER BUSINESS, PROFESSIONAL BOND

In an address before the recent annual meeting of the Ohio State Dental Society in Columbus, Delmar G. Starkey, general manager of the Columbus Chamber of Commerce, scored a ten-strike when he observed that there should be closer cooperation between business men and professional men on matters of community interest.

Pointing out that members of the dental and medical professions cannot afford to be aloof when it comes to community activity and interests, Starkey warned that this would lead to "specialization" in community affairs—something which has not been an "unmixed blessing" in the professions themselves.

This admonishment is something which physicians in every city and town should take to heart. The proper solution of community problems depends on concerted action by all groups. Physicians may feel that some particular project is outside their sphere of interest. But, they must keep in mind that they too are a part of the community and that the time might not be far off when they as a group will want the support of the business leaders of the community on matters of direct, vital concern to the medical profession.

HOW NOT TO GET BUSINESS AND WIN FRIENDS

Dr. Howard Holmes, president of the Toledo Academy of Medicine, writing in the "President's Corner" of the *Toledo Academy Bulletin*, points out that in investigating statements such as, "If we get socialized medicine, the physicians will have only themselves to blame," he finds that many of these statements are based on facts—at least factors which are driving many persons into the corner of those who want a governmental medical program.

The following observation is made by Dr.

Holmes, and it can't be laughed off or dismissed with the retort, "It must be the other fellow; I'm not guilty":

"The rumblings caused by excessive charges made by many medical men also must be recognized as a factor in this program. It has been told to me by other physicians as well as lay individuals of such experiences as this.—The so called white collar class which has been rather hard pressed during the last few years have been made to pay fees out of proportion to their ability. Many of these people are complaining and have been doing much talking detrimental to medicine. Variations in fees made by different doctors cause some comment. There is still a wide divergence of opinion even among our medical group as to what constitutes a legitimate fee. Any type of insurance, voluntary or compulsory will of necessity place somewhat of a standard schedule on our services and it will be our duty to accept such a schedule without too much antagonism if we wish to retain our individuality as practitioners of medicine."

There are some physicians who won't like Dr. Holmes' comment. They are the ones who cast one eye on a patient and the other on the cash register. Their tactics are giving the socializers plenty of arguments in favor of national health insurance.

JOHN L. LEWIS' VIEWS ON U. M. W. MEDICAL PROGRAM

In the November issue, a few comments regarding the United Mine Workers' medical and hospitalization fund were offered, including a warning that the medical profession should keep in close touch with developments of this program.

In view of this, an article published in the November 19 issue of *U. S. News and World Report* is exceedingly timely. The article is an interview of John L. Lewis, United Mine Worker president, by members of the editorial staff of the *U. S. News and World Report*.

When requested to discuss how much of the welfare fund of the U. M. W., raised by a royalty on each ton of coal mined, would be needed for the organization's medical and hospital program, Mr. Lewis replied:

"It is not our purpose to erect hospitals or conduct medical centers or establish or maintain our own medical clinics, but to utilize the existing medical and hospitalization centers, making contracts with them for their service at acceptable standards. It is our purpose to remove the cost of that service from the mine workers who are now bearing it to the industry itself and have the cost paid by the fund. In most of our mountain states, and it is particularly true in Southern sections, men pay \$2.50 to \$3.50 a month each, which is deducted from their pay, for medical service from the company doctor. They also pay an amount approximating that monthly for hospital service. That's a burden—that \$6.00 or \$8.00 a month per man. Many of these company doctors are men of no great repute in the profession. The hospital facilities

are oftentimes far removed from the best medical standards. It is the purpose of the fund to encourage the expansion of existing facilities. In this respect I think we have the cooperation of the American medical profession and we are moving slowly in that field because we want to be assured that we are moving properly and correctly and with sound judgment."

Whatever may be said regarding the fundamental principles of the U. M. W. fund or of the record of Mr. Lewis as chief of the organization, it is difficult to find any fault with the views expressed above. It appears as if Mr. Lewis has left it to the medical profession and hospital authorities to write their own ticket within reasonable bounds. It's a challenge which they dare not sidestep, for don't forget it, other labor organizations are watching the U. M. W. innovation with more than casual interest. If the medical profession and hospitals can muster the proper facilities and personnel, and do their job in line with acceptable standards, they may find this arrangement their best weapon against compulsory governmental schemes.

EXAMPLE FOR PHYSICIANS SET BY DRUGGISTS

In cooperation with the school officials of Youngstown, members of the Mahoning Valley Pharmaceutical Association have suspended the sale of comic books pending a report of a screening committee on the types of comic books which are suitable reading for children.

The Mahoning Valley druggists are to be congratulated for being farsighted and for doing a good turn for their communities. Through their action they undoubtedly have won lots of good will. Also, they probably have thwarted possible legislative action by the city councils of their area. By taking voluntary action of this kind, professional groups frequently can do themselves as well as the community a real service. The medical profession should be on the alert for opportunities to take similar action within its own field of activity.

HEALTH COMMISSIONERS' MEETING OF PRACTICAL VALUE

We don't know what the reaction of the county and city health commissioners was on the type of program presented at the recent mandatory conference of the commissioners with the Ohio Department of Health but it appealed to us as a definite improvement over past conferences.

The program was built around group conferences on public health activities which are required by law or regulation, with reports and recommendations back to the general conference for discussion and action. It certainly was a practical program, in our opinion, giving the public health officials a chance to find out what

is being done in other communities, get questions answered, and offer suggestions to the officials of the state department.

There's nothing better than getting down to brass tacks on what to do and how to do it, without too much emphasis on theory and research. More meetings of that type will add pep and initiative to Ohio's public health program, we believe.

A LESSON FROM THE LIFE OF A PIONEER PHYSICIAN

No better example of how a physician can engage in honest-to-goodness, day-by-day public relations which enhances his own standing and that of the entire medical profession can be found than the story of the life of Dr. Rufus W. Stearns, pioneer physician of Mercer County.

Readers of *The Journal* who read the articles concerning him in "The Historian's Notebook" in the September and October issues must have received a real inspiration. Those who did not read those articles should do so, then go and do likewise.

Dr. Stearns made himself one of the outstanding men in that community more than 100 years ago, not only because he was an excellent physician but because he also was a community builder. As his great grandson, author of the articles, pointed out, Dr. Stearns made liberal financial contributions to civic enterprises. He assisted in community planning (laying out of streets, buildings, trees, etc.). He was a member of the first City Council of the town of St. Marys and he took an active part for years in the governmental affairs of the area. Dr. Stearns was prominent in establishing a public school system for his community and served on the administrative board. His interest in religious and church activities was intense. He engaged in many similar activities, too numerous to repeat here.

His great grandson in telling the story, makes this pertinent observation:

"Dr. Stearns had lived a hard but very profitable life. He labored tirelessly as a physician and surgeon, and attained a reputation for taking the time to advance many organizations necessary for the development of his community. Largely through the efforts and actions of doctors such as Rufus W. Stearns the medical profession has achieved standards that cannot be excelled. The doctor in those pioneer days was one of the most valuable members of the community, for he administered not only to the needs of the body, but to the needs of the soul, and the community as a whole."

If the pioneer physician of 100 years ago could find the time to do things for his people

and community outside the line of duty, surely today's physician can. If the community work of the pioneer physician paid dividends—and it did—similar activities will do the same today. If the things which Dr. Stearns did a century ago won for him the devotion and confidence of the people of Mercer County and elevated the standing of the medical profession as a whole, physicians in 1948 A.D. should follow the trail he blazed.

In our opinion, many of the trials and tribulations of many physicians today—in fact of the entire medical profession—are the direct result of the failure of so many physicians to recognize the importance of taking an active part in those affairs which are designed to improve the community in which he lives and practices.

THIS KIND OF READING IS GOOD READING

Following is an excerpt from a recent issue of the *Sandusky Register-Star News*:

"Dr. H. W. Lehrer, retiring chairman, in his report to the group stated detection and control of cancer in Erie County had made substantial progress in recent years. This has resulted largely from the organized efforts of the local unit of the American Cancer Society in spreading education regarding the disease and in co-operating with the Erie County Medical Society and the hospitals in providing facilities for more alert diagnosis and treatment."

That's the kind of publicity which pays dividends for the medical profession. Please note that a physician was chairman of the local cancer society and that the Erie County Medical Society is credited with having cooperated with the cancer group on activities which made the program in Erie County click. Any county medical society can get plenty of publicity of this kind if it will just hit the ball.

BITTER PILLS FOR MR. BEVAN

Britain's new national health service scheme is becoming a bitter pill even for Minister of Health Bevan who engineered the plan through Parliament for the Labor Government. According to the British correspondent to *The Journal of the A. M. A.*, doctors there are so flooded with patients with slight ailments that they do not have time to take care of those with serious conditions. This was confirmed by Mr. Bevan, who sadly commented that "because things are free is no reason why people should abuse their opportunities." The Minister of Health should dust off the old refrain, "Don't Bite the Hand That Feeds You." Mr. Truman and Mr. Ewing please note.

Drs. Whitacre and Portmann To Head National Specialty Societies

Two Cleveland physicians have been honored by being named presidents-elect respectively of two national medical specialty organizations.

Dr. Roland J. Whitacre, director of the Department of Anesthesia, Huron Road Hospital, East Cleveland, has been named president-elect of The American Society of Anesthesiologists, Inc. He will succeed Dr. H. Boyd Stewart of Tulsa, Okla., as president of the Society in 1949.

Dr. U. V. Portmann, head of the Department of Therapeutic Radiology at the Cleveland Clinic, has been chosen president-elect of the American Roentgen Ray Society.



R. J. WHITACRE, M. D.

and member of the Board of Governors of the International Anesthesia Research Society, and past-president of the Ohio Society of Anesthesiologists and the Cleveland Society of Anesthesiologists.

He has been associate editor of *Anesthesiology* since 1946, and a member of the editorial board of *Anesthesia and Analgesia* since 1941. He was chairman of the Cleveland Anesthesia Study Commission from 1945 through 1947 and is the present secretary of the organization. He was active in the formation of the Cleveland and the Ohio Study Commissions, whose main purpose is to receive reports of cases in which complications or death follow the administration of anesthesia and to discover the possible causes.

Dr. Portmann has written more than 75 medical articles and holds membership in numerous medical societies. He is a charter member of the Ohio State Radiological Society and of the Cleveland Radiological Society and has been president of both. He also is a member of the American Board of Radiology, formerly was secretary and now is vice-chairman of the Section on Radiology of the American Medical Association.

At Western Reserve University, Dr. Portmann

was captain of the football team in 1908 and was a member of the Glee Club and the track team. After receiving his degree from the School of Medicine and completing his internship at St. Vincent's Charity Hospital in Cleveland, he returned to his native Minnesota. He continued in practice in that state, except for the time he spent in the Army Medical Department during World War I, until 1922, when he joined the staff of the Cleveland Clinic



U. V. PORTMANN, M. D.

as director of therapeutic radiology.

Buckeye News Notes . . .

Akron—The Doctors Orchestra opened its 23rd season with rehearsal on Oct. 21.

Alliance—Dr. R. L. Rutledge, immediate Past-President of the Ohio State Medical Association, addressed a meeting of the Kiwanis Club on November 18 on the subject, "How Will You Have Your Doctor?"

Ashtabula—The subject, "Advancement in Medical Science," was discussed by Dr. Clarence E. Case at a recent meeting of the Rotary Club.

Columbus—Dr. Louis L. Praver presented an illustrated talk on "Cancer of the Skin, Mouth and Throat," as one of a series of lectures on cancer control at the Central Y. M. C. A.

Columbus—Dr. Hugh E. Setterfield, Ohio State University College of Medicine, national president of Alpha Epsilon Delta, installed the Pre-Medical Club of the University of Miami, Florida, as the Florida Gamma Chapter of the honorary pre-medical fraternity.

Columbus—Dr. Robert G. Smith has been appointed chief surgeon for the Santa Fe Railroad with headquarters in Topeka, Kans., effective December 1.

Massillon—Dr. Clifford S. Palmer of Massillon was elected Governor of the Ohio District of Kiwanis International at the recent district convention in Dayton.

Springfield—Dr. Delos W. Hogue, former Councilor for the Second District, discussed "Our Medical Problems" before the Men's Literary Club, a group of business executives, educators and other professional men.

Youngstown—Dr. E. J. Reilly, a past president of the Mahoning County Medical Society, was elected president of the recently organized Medical Service Foundation of Mahoning County.

Do You Know? . . .

New officers of the American Academy of Ophthalmology and Otolaryngology include Dr. Fred W. Dixon Cleveland, first vice-president, and Dr. Donald J. Lyle, Cincinnati, second vice-president.

* * *

The American Academy of Cleft Palate Prosthesis will meet at the Ohio State University College of Dentistry, Columbus, March 21-22, 1949. Interested physicians are invited to attend the meeting.

* * *

Dr. John A. Toomey, professor of clinical pediatrics and contagious diseases at Western Reserve University School of Medicine, has been granted a sabbatical leave to rest and do private practice in Miami, Florida. Dr. Morris Schaeffer, assistant professor of pediatrics, has been named acting director of the contagious department at the Cleveland City Hospital.

* * *

Based on a survey in 25 states, the National Society for the Prevention of Blindness estimates that one-fifth of all school children have defective vision.

* * *

Dr. Howard Dittrick, associate professor of medical history, Frank E. Bunts Educational Institute, Cleveland, recently addressed a joint meeting of the Institute of Medicine of Chicago and the Society of Medical History of Chicago, on "Temple to Hospital in Care of the Sick."

* * *

The Department of Justice has begun a nationwide investigation of the artificial eye industry.

* * *

Dr. Charles A. Doan, Dean of the Ohio State University College of Medicine, is a member of the Board of Directors of the National Society for Medical Research.

* * *

A resolution demanding that the Veterans Administration permit chiropractors to treat veterans requesting their services, was defeated at the national American Legion convention in Miami, Oct. 17-21.

* * *

"Live Long and Like It" is the title of a 32-page factual pamphlet, stressing the importance of geriatrics, recently published by the Public Affairs Committee, Inc. The author is Dr. C. Ward Crampton, chairman of the sub-committee on Geriatrics of the Committee on Public Health, Medical Society of the County of New York. Copies of the pamphlet are available for 20 cents each from the Public Affairs Committee, Inc., 22 East 38th St., New York 16.

Membership in the Ohio State Medical Association reached a new high—7,312—on Nov. 15. The total on Dec. 31, 1947, was 7,106.

* * *

Twenty-one nations have made arrangements to receive beneficial radioactive isotopes from the uranium chain-reacting pile at the Oak Ridge National Laboratory for medical and biological research. They are: Argentina, Australia, Belgium, Canada, Cuba, Denmark, France, Iceland, India, Ireland, Italy, the Netherlands, New Zealand, Norway, Peru, Spain, Sweden, Switzerland, Turkey, Union of South Africa, and the United Kingdom.

* * *

According to the *American Journal of Public Health*, there were 19,000 amputations among American military personnel during World War II, but over 120,000 major amputations during this same period among our civilian population. During the war approximately 1,500 men were blinded while in military service, but 60,000 civilians lost their sight during the same period. Combat injuries resulted in 265,000 men being permanently disabled during the war, but 1,250,000 civilians were permanently disabled by disease and accident during the corresponding four-year period.

* * *

Dr. Joseph M. Hayman, Jr., professor of medicine, Western Reserve University School of Medicine, Cleveland, was one of the civilian medical consultants who participated in a conference of Army medical officers under the auspices of the Surgeon General of the Army, Oct. 20, in Tokyo. Dr. Hayman spoke on "The Collagen Diseases."

* * *

New officers of the Ohio State Eclectic Medical Association are: Dr. H. A. Martin, Gratiot, president; Dr. Weldon E. Diller, Rawson, vice-president; and Dr. T. H. Einsel, Cleveland, secretary-treasurer.

* * *

Martins Ferry Hospital is building an addition through the generosity of Dr. R. H. Wilson, Belmont County's oldest practicing physician, who recently presented the hospital with a gift of \$60,000.

* * *

Dr. Robert L. Alter, Toledo, has been named professor and head of the department of obstetrics and gynecology at American University, Beirut, medical center of the Near East.

* * *

Dr. Winchell McK. Craig, Rochester, Minn., a native of Washington Court House, is the new president of the Harvey Cushing Society.

Income and Other Taxes . . .

Physicians Advised To Study Closely Changes in Income Tax Assessments And Regulations; May Mean Vast Difference in Year's Returns

THE "Revenue Act of 1948" effects a number of changes in the Federal income tax structure among which are substantial reductions in individual taxes through the medium of percentage tax reductions and increased exemption amounts.

Perhaps one of the most substantial changes is in the provision for "splitting income" of married couples. A new section has been added to the law which in effect places individuals in a non-community property state (such as Ohio) on the same basis for income tax purposes as those living in community-property states. That is, a husband and wife in many cases may effect substantial reductions by splitting their income on a joint return. On such a joint return, the taxable income (adjusted gross income less optional standard or ordinary deductions and less exemption credits) is then divided in half and a tentative tax computed on half the income.

In addition to the reduction in rates because of the computation being made only on half the income, credits are provided after arriving at the amount of the tentative tax. There is to be deducted 17 per cent of the first \$400 of such tentative tax, or \$68. If tax is in excess of \$400, the deduction will be \$68 plus 12 per cent of the amount in excess of \$400. The net tentative tax is then multiplied by two to arrive at the total tax liability.

PERSONAL EXEMPTIONS AND CREDIT FOR DEPENDENTS

The personal exemption has been increased to \$600 for the taxpayer and his spouse. Therefore, on a joint return of husband and wife, this credit would be \$1,200. If, however, either spouse has reached the age of 65, an additional exemption of \$600 is allowable. If either is blind, an additional \$600 exemption may be claimed.

FORMS AND PAYMENTS

Every person whose gross income for 1948 was \$600 or more must file certain income tax returns with the Collector of Internal Revenue for his district, not later than March 15, 1949.

Every physician who comes within the provisions of the Income Tax Law must do the following:

1. File an actual return for 1948. Returns may be filed on either form 1040 or 1040a. However, the form 1040a does not make provision for any allowable deductions and the tax must be computed by using the table. Those who have incomes in excess of \$5,000 or who wish to take advantage of allowable deductions must use form 1040. Form 1040 has two classifica-

tions—a short form and a long form. The long form is required only where the taxpayer wishes to list his payments for charity, interest, taxes and other allowable deductions.

2. Pay the difference, if any, between the income tax paid during 1948, based on the estimated return for 1948 which he filed during that year and the amount of the tax computed on his final return for 1948 filed on or before March 15, 1949. If he has overpaid, the excess amount will be refunded or credited against

While the accompanying information concerning Federal income tax is authentic and is based on material supplied by Mr. S. F. Noggle, Columbus, for many years chief of Income Tax for the 11th Ohio Internal Revenue District, physicians are advised to obtain advice and assistance in the preparation of their returns from competent legal or tax authorities or from staff members in the office of District Collectors of Internal Revenue.

future tax payments. Amounts refunded carry interest at six per cent from March 15, 1949, to date of payment.

3. File a declaration of estimated tax for the year 1949, and pay one fourth of the estimated tax for 1949, the balance payable quarterly thereafter. Blanks for filing the 1949 return will be mailed to taxpayers of record by the district collectors of internal revenue. If estimated returns for 1949 are based on 1948 income and the tax computed at the 1949 rates, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

REPORT ON FUNDS PAID

While it is necessary this year to report salaries of office assistants and other employees whose salaries are subject to the withholding tax, as in previous years payments in excess of \$500 made during 1948 for interest, rents or commissions, not subject to withholding and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15, 1949, to the Commissioner of Internal Revenue, Processing Division, Kansas City, Mo.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of In-

ternal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue, Customs Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

ADJUSTED GROSS INCOME

Individuals who are employed and receive a salary have no difficulty in arriving at the amount of their adjusted gross income. The total salary received plus any amounts which might be received from interest or dividends would in such cases constitute the gross income.

The physician has more difficulty in arriving at his adjusted gross income. From the amount of his cash receipts—if he reports income on the basis of cash received and disbursements, or on the amount of total charges if he uses accrual method of reporting his income—he may deduct all items of expenditure necessary in earning his income. These items are described in more detail in the following sections.

DEDUCTIBLE BUSINESS EXPENSES

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he cannot claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and

attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Depreciation may be deducted on an automobile used in professional business. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held not to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in attending medical conventions for a professional purpose are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicines, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chem-

icals and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (i.e., all fees, either cash or account are included in income reported for tax purposes) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using the latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible. Taxes on one's own home are not to be considered as business expenses, such taxes being allowable as ordinary deductions only. All license fees which the physician is required to pay, including narcotic tax and local occupational taxes, are deductible. The cost of an automobile license, unless the car is used exclusively for business, is to be taken as an ordinary deduction only. The tax paid on telephone bills, if the telephone is used for business only, is deductible as a business expense. This would apply to office phones. The tax paid on other telephone bills would be deductible only as an ordinary deduction. Federal taxes on amusements, club

dues, furs and luxuries are not deductible for Federal income tax purposes.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible in returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. Social Security taxes withheld by an employer are not deductible by the employee in computing his tax liability.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Sales Tax Payments—The sales tax paid in connection with purchase of items used in business become a part of the cost thereof and as such are not deductible as business expenses. Other amounts expended for sales tax are ordinary deductions and not to be taken as business expenses.

Ohio Gasoline Tax—This tax is deductible to the extent of four cents per gallon. However, if a physician has already included cost of gasoline as part of his business expenses, the tax is not again deductible. The tax paid on gasoline not used in business is deductible as an ordinary deduction.

Interest—Amounts paid as interest on business indebtedness may be taken as business expenses. Interest items paid on personal indebtedness are deductible only as ordinary deductions. Interest paid to carry tax free securities may not be deducted.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair, and the cost of the repair is claimed as a deduction.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is not deductible.

ORDINARY DEDUCTIONS

In addition to items mentioned in the foregoing paragraphs which would not fall under the cate-

gory of ordinary deductions, the following may be taken under that heading:

Contributions, Gifts, Etc.—It is permissible to deduct from gross income contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 15 per cent of the adjusted gross income.

Optional Standard Deductions—The optional standard deduction permitted in lieu of listing amounts paid for contributions, interest, taxes and other ordinary deductions, has under the provisions of the Revenue Act of 1948 been increased. Under the old law, the maximum standard deduction was \$500. Under the new act, the optional standard deduction is 10 per cent of the adjusted gross income, but not in excess of \$1,000.

Medical and Dental Expenses—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of five per cent of the adjusted gross income. In the case of a husband and wife filing a joint return, the expenses are not deductible unless they exceed five per cent of the aggregate adjusted gross income of both. The maximum allowable deduction on a joint return is \$2,500 plus \$1,250 for each dependent listed on the return, not to exceed two. The maximum deduction is \$5,000. The maximum allowed for a single person with no dependents is \$1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accidents or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

OLD AGE BENEFITS TAX

The Old Age Benefits Tax is payable by every physician who employs one or more persons in his office. The employer must contribute one per cent on the first \$3,000 of each employee's wage, and a like amount is deducted from the wages of each employee. The tax return and informational return, combined in one report, is to be filed quarterly. The tax must be paid and the return filed prior to April 30, 1949, for the months of January, February and March, 1949, in the office of the District Col-

lector of Internal Revenue, and quarterly thereafter, payable the month after the quarter ends.

UNEMPLOYMENT COMPENSATION TAX

Under the Ohio Unemployment Compensation Law, physicians who employ three or more persons must file an "Employer's Contribution, Form UCO-2-e, Report," and Form BUC-475X report of individual worker's wages, quarterly with the Ohio Bureau of Unemployment Compensation, Columbus. Contribution reports for any calendar quarter are due within the month immediately following the quarter. The tax, which must accompany the return, amounts to 2.7 per cent of the quarterly payroll, unless qualified for a modified rating, known as the experience rating.

Employers of eight or more persons in 20 weeks during a calendar year, under the Federal Unemployment Excise Tax, must have filed with the District Collector of Internal Revenue on Form 940, prior to January 31 of each year, a report of wages paid during the preceding year.

The tax is three per cent, less a credit amounting to 90 per cent of the Federal tax if the employer of eight or more has paid his contributions in full to the Ohio Bureau of Unemployment Compensation. In effect any such employer whose state tax liability is paid in full need pay a rate of only three-tenths of one per cent under the Federal tax act.

OHIO USE TAX

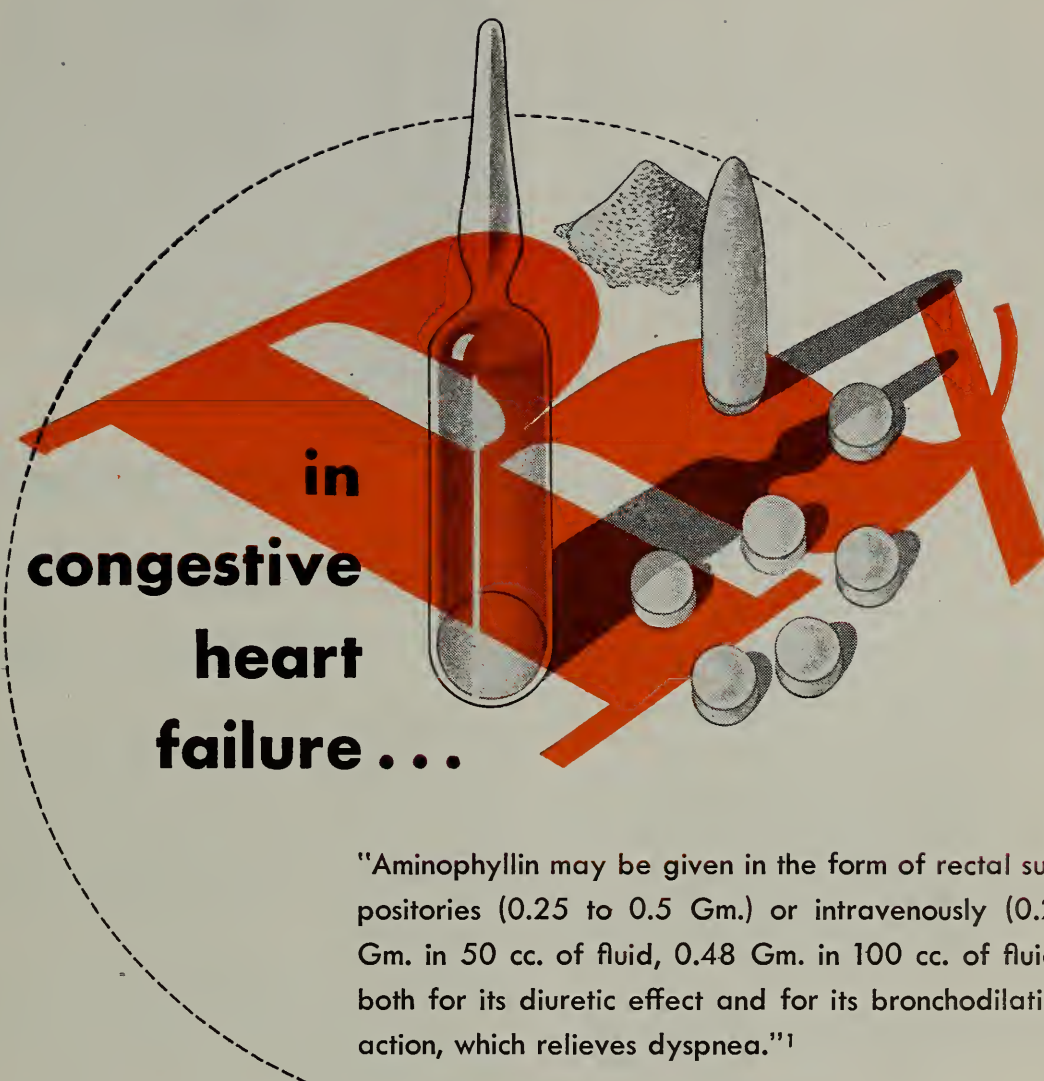
The Ohio Use Tax Law, passed in 1936, supplementing the Retail Sales Tax Law, imposes a tax on the same basis as the sales tax, on purchases made outside the state. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department. However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15, 1949, for purchases during the period January 1 to March 31, 1949, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

OHIO PERSONAL PROPERTY TAX

There have been no fundamental changes in the Ohio Personal Property Tax provisions.

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31 annually. One half the amount of the tax is paid when the return is filed, and the other half is due September 20.

The State Tax Commissioner is currently con-



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heart
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Research in the Service of Medicine

1. Orgain, E. S.: The Treatment of Congestive Heart Failure, North Carolina M. J. 8:125 (March) 1947.

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

ducting a campaign to increase efficiency in the collection of this tax, and penalties are being assessed against those who have been delinquent or have failed to declare personal property for taxation.

All intangible personal property in possession of a physician on January 1, 1949, and tangible personal property (not real estate) used by him in his business, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies, etc.

Such returns should be made in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

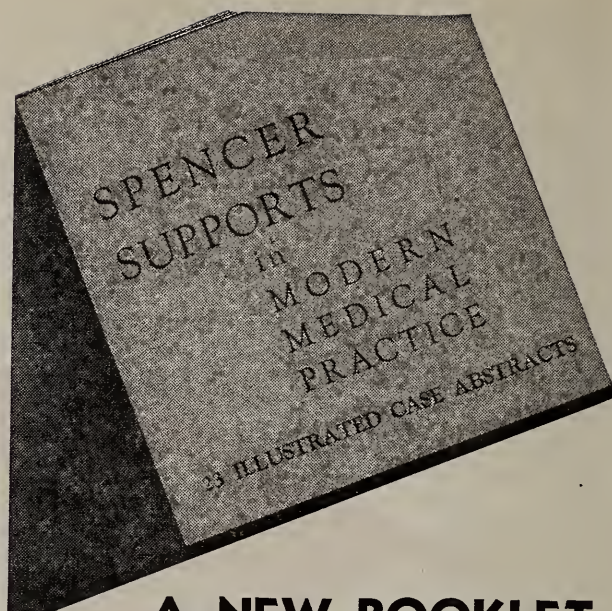
One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1948 return he would be permitted to return as of "no value" accounts receivable which he listed in 1947 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1947 but which have decreased in actual value during the past year.



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In Memoriam . . .

Clarence Truman Bahler, M. D., Walnut Creek; Western Reserve University School of Medicine, 1917; aged 61; died October 23; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1947; president of the Holmes County Medical Society 1933-35 and its secretary 1931-35. Dr. Bahler practiced in and around Walnut Creek for 29 years. He was active in the work of the Reformed Church and for a number of years served as organist. Surviving are three brothers, including Dr. Clyde Bahler, also of Walnut Creek, and a sister.

Curtis Leroy Baker, M. D., Kirkpatrick; Medical College of Indiana, 1894; aged 79; died October 15; member of the Ohio State Medical Association and a Fellow of the American Medical Association; president of the Marion County Academy of Medicine in 1938 and a delegate of the Academy to the Ohio State Medical Association in 1939. Dr. Baker practiced for more than 50 years in and around Kirkpatrick. In addition to his professional practice, he was active in community and school work; was a member of the Church of Christ, the Masonic Lodge and was a 50-year member of the Knights of Pythias. Surviving are his widow, a son and a daughter.

Harold Winston Eckel, M. D., Westwood; University of Cincinnati College of Medicine, 1938; aged 35; died November 5; member of the Ohio State Medical Association and the American Medical Association. Dr. Eckel served during the war with the medical corps of the Army Air Corps. He was associated in practice both before and after his military service with Dr. H. R. Fullerton. Surviving are his widow and two young sons.

Daniel Sylvester Gardner, M. D., Massillon; Western Reserve University School of Medicine, 1887; aged 81; died October 26; former member of the Ohio State Medical Association and the American Medical Association through 1922. Dr. Gardner spent his entire professional career in Massillon. Surviving are his widow and a son.

Orrin W. Haulman, M. D., Youngstown; Western Reserve University School of Medicine; aged 60; died November 3; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Haulman, in addition to his practice of medicine, was active in civic and fraternity work. He held membership in Phi Ro Sigma fraternity, the Reformed Church, the Masonic Lodge and the Youngstown Club. He was an ardent sportsman and hunting and fishing enthusiast. His widow survives.

Charles Edward Horner, M. D., Williamsburg; Eclectic Medical College, Cincinnati, 1907; aged 66; died October 11. Dr. Horner before his retirement five years ago, practiced in Newport. Surviving are his widow, two sons and two daughters.

Samuel Emerson McMasters, M. D., Akron; Ohio Medical University, Columbus, 1906; aged 67; died October 30; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. McMasters practiced in Akron for more than 40 years. He was a member of the Methodist Church and the Masonic Lodge. Surviving are a sister and a brother.

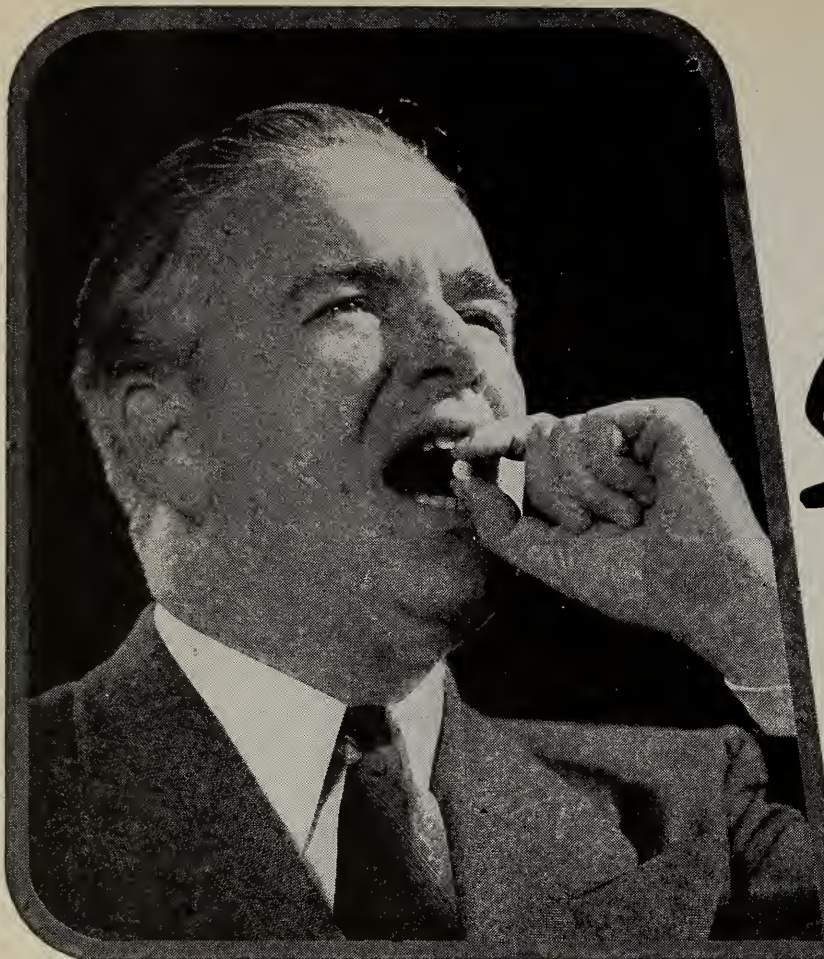
Edward Meadow, M. D., Miami, Fla.; Loyola University School of Medicine, Chicago, 1935; aged 39; died October 10; former member of the Ohio State Medical Association and Fellow of the American Medical Association through 1939. Dr. Meadow formerly practiced in Canton before leaving for Florida in 1938. Surviving are his widow, his parents and two sisters.

Marshal Chalmers Morgan, M. D., Akron; Ohio State University College of Medicine, 1913; aged 61; died November 5; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Morgan practiced his profession in Akron for 35 years. He was a member of the United Presbyterian Church and the Masonic Lodge. Surviving are his widow, three sons including Dr. Charles Morgan, also of Akron, three brothers and a sister.

Warren Garfield Murray, M. D., Dixon, Ill.; Ohio Medical University, Columbus, 1906; aged 66; died October 13 at Rochester, Minn.; member of the Illinois Medical Association and a Fellow of the American Medical Association; member of the American Psychiatric Association. Dr. Murray was a native Ohioan. He spent more than 30 years of practice in Illinois, most of which time he was director of the Dixon State Hospital.

Isaac Machol Rubin, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1906; aged 68; died October 22; member of the Ohio State Medical Association and a Fellow of the American Medical Association. Dr. Rubin's entire professional life was spent in Cleveland. Surviving are his widow, a daughter, two brothers and four sisters.

Glen DeWitt Sheets, M. D., Williamsport; Ohio State University College of Medicine, 1920; aged



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55; died October 17; former member of the Ohio State Medical Association and the American Medical Association through 1941; president of the Pickaway County Medical Society in 1931; its vice-president in 1925-26, and chairman of the legislative committee in 1932. Dr. Sheets practiced medicine in Williamsport for 27 years. He was a veteran of World War I, and a member of the Masonic Lodge. His mother survives.

Clyde Byron Terwillegar, M.D., Steubenville; University of Cincinnati College of Medicine, 1912; aged 58; died October 23; former member of the Ohio State Medical Association and a Fellow of the American Medical Association through 1941; president of the Jefferson County Medical Society in 1925. Dr. Terwillegar practiced in Steubenville until his retirement about eight years ago. He was affiliated with the Masonic Order and the Elks Club. Surviving are his widow, a daughter and a son.

Joseph Llewellyn Todd, M.D., Canton; University of Pittsburgh School of Medicine, 1895; aged 81; died October 23. Dr. Todd had retired from active practice a number of years ago. He was a member of the United Presbyterian Church and a 50-year member of the Masonic Lodge. Surviving are his widow, a daughter and a brother.

William E. Wheatley, M.D., Lorain; Western Reserve University School of Medicine, 1894; aged 77; died October 25; member of the Ohio State Medical Association; and a Fellow of the American Medical Association; member of the American College of Surgeons. Dr. Wheatley practiced in Lorain from 1900 until his retirement about a year ago. For a number of years he was physician for the National Tube Company. He was a past president of the Rotary Club; held memberships in several Masonic Orders; was a member of the Knights of Pythias and the Elks Club. Surviving are two daughters, a son and three sisters.

Honored by Japan

Dr. Edward J. McCormick of Toledo, member of the Board of Trustees of the American Medical Association, has been named an honorary member of the Japan Medical Association, according to a communication from its president, Akira Takahashi.

"Your recent visit to Japan, as an official representative of the American Medical Association as well as a professional friend, has had a far-reaching effect in improving the standards of medical care and awakening the entire profession to the new possibilities in serving our people," the letter stated.

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Health Commissioners Conference . . .

Representatives of Local Health Units Hold Free Discussions on Needs Throughout Ohio and Make Some Pertinent Recommendations

IN a distinct departure from previous years, when scientific discussions occupied the the major role, Ohio health commissioners, at their 29th annual conference with the Ohio Department of Health, were given an opportunity to engage in businesslike discussions involving their needs, duties and their problems.

The commissioners not only approved the change in the nature of their meeting, but also established an official organization entitled "Conference of Ohio Health Commissioners" and adopted for it a set of by-laws.

The purpose of the new organization, as set forth in the by-laws, is to ". . . serve as a medium for the interchange of information and viewpoints and for the development and promotion of procedures relating to all phases of public health, including those which are interdistrict or state-wide in scope." The State Director of Health is to be the chairman of the group. A vice-chairman and secretary are named from among the local officials. The officers and two additional nominees constitute the executive committee.

The Conference itself, held October 21 and 22 in Columbus, was divided into five committees

with various subcommittees, which discussed problems common to their respective fields and recommended administrative procedures and proposed state legislation for improvement of public health.

Their decisions were then submitted to the Conference as a whole for consideration and inclusion in the organization's program.

Chief among the recommendations of the Conference were:

1. That, as a "necessity," the Ohio General Assembly appropriate sufficient funds to the Ohio Department of Health to support that Department's statutory responsibilities, so that Federal grant-in-aid funds may be more completely devoted to local health departments as supplements to local funds.

2. That the Ohio Department of Health introduce legislation on stream pollution, to comply with the Ohio River Valley Sanitation Compact which was signed last Spring.

Other departmental recommendations submitted included the following:

Development of training programs for all staff members of local health departments.

Appointment of a standing committee of the



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For the GENERAL PRACTITIONER

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Conference to investigate, along with other agencies, the question of obtaining adequate local fiscal support for local health departments and to improve methods of obtaining such funds.

Endorsement of a proposal that as a "necessity" the Ohio General Assembly appropriate sufficient funds to meet matching provisions for local health departments.

That a maximum of \$15 and a minimum of \$10 per session be paid to a pediatrician or general practitioner attending a well-child conference in local health districts.

That physicians in rural areas where there are no hospital facilities, be encouraged to develop one-bed maternity hospitals.

That local health departments assume increasing responsibility for local crippled children.

That an adequate follow-up program be scheduled before an X-ray case finding program is carried out.

That local health commissioners be informed of contemplated hospital construction under Public Law 725, so that consideration may be given to improvement of health facilities, where such action is warranted.

That the Ohio Department of Health furnish local departments with penicillin for operating venereal disease clinics.

That the use of any public water supply as a means of administering any medication, such as sodium fluoride, be opposed.

That the Public Health Council adopt basic sanitary regulations covering the development of rural water supplies and installation of rural sewage disposal.

Additional recommendations requiring legislation were:

Ban on the dumping of garbage and rubbish along public highways.

Uniform milk regulations for Ohio.

Minimum local per capita expenditure of one dollar for health purposes.

Sounder basis for state subsidy.

State hospital licensure law.

State registration of marriages, divorces, annulments and adoptions.

Closing of school buildings when the board of education refuses to abate a nuisance.

Endorsement of appropriate legislation to place licensing and inspection of restaurants in Ohio Department of Health.

Officers of the newly formed organization include: Dr. John D. Porterfield, State Director of Health, chairman; Dr. W. H. Hartung, Toledo Health Commissioner, vice-chairman; and Dr. J. P. Owens, Hamilton County Health Commissioner, secretary. Dr. F. E. Mahla, Health Commissioner of Sandusky and Erie County, and Dr. M. D. Ailes, Akron Health Commissioner, will serve with the above-named officers on the executive committee.

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Medical Officers Needed . . .

Number of Doctors Volunteering for Service With Ohio National Guard Has Not Kept Pace With Expanding Defense Organization

EXPANSION of the National Guard of Ohio has emphasized the need for more medical officers in that organization.

Medical officers in the Guard not only are rendering a patriotic contribution, but by rendering service they are entitled to receive pay for time spent on duty (amounting in some cases to more than \$400 per year) and become eligible for accumulation of credits under the retirement act passed by the last Congress.

The foregoing facts were revealed by Lt. Colonel Carr E. Dix of Columbus, surgeon of the 37th Division, who announced approximately 25 vacancies for medical, dental and Medical Service Corps personnel throughout Ohio.

Under the National Defense Program, Ohio has been allocated approximately 27,000 officers and men as its final quota of strength. The principal units include the 37th Infantry Division, plus a task force known as the 166th Combat Team and numerous other attached ground troops. Also there is a large allocation of air force units with headquarters at Lockbourne Air Base, Columbus.

Officers of the Medical Corps who are commissioned in the Ohio National Guard receive Federal recognition as such and so become a part of the active reserve component of the Army. The duty requirements consist of weekly attendance at drill or staff conferences, and a 15-day annual training period. Attendance at drills and the training period are paid for on the basis of pay of officer personnel of the Regular Army, base pay plus longevity with commutation of quarters and rations. A captain, for example, would draw \$7.67 per two-hour weekly drill period plus what longevity pay he has accrued.

National Guard Medical Officers can serve one grade higher than the grade set up by the table of organization. Thus, a medical officer, separated from the service as a major may serve in a position calling for a captain without taking the reduction in grade.

Nondisability retirement is available to members of all civilian components of the Armed Forces. The National Guard training schedule allows each member to accumulate enough points per year to qualify for this retirement. Following are some points of the law as pertains to nondisability retirement:

Retirement pay is granted at age 60, after 20 or more years service.

Each member must complete a year of satis-

factory Federal Service for each year of pay. A year of Federal Service is a year wherein a person is credited with 50 points under the following system: One point for each day of active Federal Service; one point for each drill period or equivalent; 15 points credited for membership in any reserve component for each year of Federal Service other than active Federal duty. Points are limited to 60 per year.

Each year of service as a member of a reserve component prior to enactment of the law shall be deemed a year of satisfactory service.

Retired pay is at an annual rate equal to 2½ per cent of the active duty annual base and longevity pay, on the basis of the highest rank held in the entire span of service.

There are more than 25 vacancies in grades from first lieutenant to major in or near Cleveland, Ashland, Akron, Cincinnati, Columbus, Bellefontaine, Springfield, Toledo, and Celina.

Further information and blanks for application may be obtained by writing the Adjutant General of Ohio, Fort Hayes, Columbus.

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Activities of County Societies . . .

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

"Politics" was the subject discussed by Dr. Henry M. Luidens at the Oct. 27 meeting of the Butler County Medical Society.

CLERMONT

Dr. George E. Rockwell was host to the monthly meeting of the Clermont County Medical Society at his home near Perintown, on Oct. 20. Acute Arthritis was the subject of the program, and was opened by Dr. Pearl Zeek-Minning, of the Department of Medicine of the University of Cincinnati College of Medicine, who discussed "The Pathology of Acute Arthritis." She was followed by Dr. M. A. Blankenhorn, also of the College of Medicine, who discussed "The Diagnosis and Treatment of Acute Arthritis." First District Councilor, Dr. E. O. Swartz, was present and discussed matters of the State Association. A dinner followed the meeting.

CLINTON

Dr. H. F. Koppe spoke on the subject "Menstrual Dyscrasias" at the Oct. 5 meeting of the Clinton County Medical Society. A discussion led by Dr. R. R. Buchanan, followed the presentation. On Nov. 2, Dr. Roy L. Kile of Cincinnati addressed the Society on the subject, "Treatment of Common Skin Diseases."

HAMILTON

"Therapeutic Uses of Radioactive Isotopes" was the subject of a discussion by Dr. Carl V. Moore, Washington University School of Medicine, St. Louis, at the Nov. 9 meeting of the Academy of Medicine of Cincinnati. On Nov 23, Dr. Paul W. Greeley, University of Illinois College of Medicine, spoke on "The Role of Plastic Surgery in Treating Various Dermatological Lesions."

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

Dr. Kenneth H. Abbott, Ohio State University College of Medicine, was guest speaker for the Nov. 15 meeting of the Clark County Medical Society when he spoke on "Facial Pains—Their Differential Diagnosis and Treatment."

GREENE

Dr. Reid P. Joyce of Dayton spoke on "The Diagnosis and Management of Malignancies" at the Oct. 7 meeting of the Greene County Medical Society in Xenia.

MIAMI

Dr. Melvin Oosting of the Miami Valley Hospital, Dayton, presented the subject "Pathology

of the Breast" at the Nov. 5 meeting of the Miami County Medical Society in Piqua.

Fourth District

(COUNCILOR: CARLL S. MUNDY, M.D., TOLEDO)

WOOD

The Wood County Medical Society met for the regular dinner meeting at Don's Point Restaurant, Perrysburg, Oct. 21. It was decided to hold only one more meeting in 1948 on December 2, at which the election of officers will be held. Dr. Harlan Howe, of the Toledo Clinic, gave the paper of the evening on Gastric Ulcer. Cases were illustrated with X-ray films. A questionnaire followed the paper and a rising vote of thanks was tendered the essayist.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

A special program of the Academy of Medicine of Cleveland honoring the Cleveland Radiological Society on its 25th anniversary was held on Nov. 19. Speaker for the occasion was Dr. James F. Brailsford, radiologist to the

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting Jan. 24, Feb. 21. Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting Feb. 7, March 7. Surgical Anatomy & Clinical Surgery, two weeks, starting Feb. 21, March 21. Surgery of Colon & Rectum, one week, starting March 7, April 11. Surgical Pathology every two weeks.

GYNECOLOGY—Intensive Course, two weeks, starting Feb. 21, March 21. Vaginal Approach to Pelvic Surgery, one week, starting Feb. 14.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4. Personal Course in Gastroscopy, two weeks, starting March 7.

PEDIATRICS—Intensive Course, four weeks, starting April 4.

DERMATOLOGY—Formal Course, two weeks, starting April 18. Clinical Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

ROENTGENOLOGY—Lecture and Diagnostic Course, two weeks, starting the first Monday of every month. Clinical Course, starting the third Monday of every month.

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Queen Elizabeth's Hospital and the Royal Hospital for Crippled Children, Birmingham, England, who spoke on "Radiographic Evidence of Metastasis in Malignant Diseases."

Clinical and Pathological Section, Nov. 5—"Retropubic Prostatectomy, A New Procedure," Dr. Julian Galvin; "Carcinoma of the Colon," a demonstration by Dr. Benjamin S. Kline; "Retropertitoneal Hemorrhage," Dr. Jac Geller; "A Case of Krukenberg Tumor With Skeletal Metastases," Dr. Alen Miller; "A Fatal Case of Systemic Thrush," Dr. Harold Epstein; and "Myxedema in an Adolescent," by Dr. Sol Keffler and Dr. Leo Walzer.

Internal Medicine Section, Nov. 10—"Stellate Ganglion Block in Treatment of Cerebral Vascular Lesions," Dr. William A. Nosik, and "Dicumarol Therapy in Cardiovascular Lesions," Dr. Fay LeFevre.

Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine, Nov. 12—"Effect of Hepatectomy and of Hepatectomy with Nephrectomy on the Responses of Controlled Hemorrhagic Hypotension in Dogs," Dr. John Reinhard and Dr. Irvine H. Page; "Diet and Hormones in Survival After Bilateral Nephrectomy," Georges Masson, Ph. D., and Dr. A. C. Corcoran; "Effect of Cord Section at L-1 on Renal Responses to Tourniquet Shock in Dogs," by Dr. A. C. Corcoran, Dr. R. D. Taylor, and Dr. I. H. Page.

Industrial Medicine and Orthopedic Section Nov. 17—"Reconstruction of the Hand," Dr. A. C. J. Brickel; "Traumatic Amputation of Fingers" and "Unusual Trauma of the Hand," by Dr. James E. Hallisy; and "Looking Over Some Overlooked Fractures," Dr. Donald E. Dial.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

PORTAGE

Guest speaker at the Nov. 4 meeting of the Portage County Medical Society was Dr. John D. Brumbaugh, Akron, who gave an illustrated talk on medical and surgical considerations in treating the eye.

SUMMIT

Members of the Summit County Medical Society had as guest speaker at their Nov. 2 meeting, Dr. Robert M. Stecher, Western Reserve University Medical School, Cleveland, who spoke on "Medical Considerations of Arthritis and Rheumatism."

Seventh District

(COUNCILOR: R. J. FOSTER, M.D., NEW PHILADELPHIA)

BELMONT

The Belmont County Medical Society held an afternoon meeting followed by a dinner on Nov. 18 at Martins Ferry Hospital. Speakers were

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Dr. Frederick S. Coombs who spoke on "Laboratory Procedures for the General Practitioner," and Dr. Gordon G. Nelson whose subject was, "Importance of Routine Pelvic and Rectal Examinations."

#### TUSCARAWAS

Members of the Tuscarawas County Medical Society were guests of the Bowman Bros. Drug Company, Canton-Akron, at Bonvechio's Restaurant, Wainwright, for the November meeting. Dr. Robert E. Wolfe, Uhrichsville, was principal speaker basing his talk on obstetrics films.

#### Eighth District

(COUNCILOR: CHESTER P. SWETT, M.D., LANCASTER)

#### MUSKINGUM

A motion picture produced by the American College of Surgeons, entitled "Anomalies and Diseases of the Bile Ducts and Blood Vessels," was shown at the Nov. 3 meeting of the Muskingum County Academy of Medicine under direction of Dr. Warren H. Cole of the University of Chicago.

#### WASHINGTON

The Washington County Medical Society was host at the Betsey Mills Club on Oct. 28 to doctors of the Eighth Councilor District. Following a luncheon, Dr. C. Edgar Northrup, Jr., president of the Eighth Councilor District, presided at a business session. After the scientific section, the Woman's Auxiliary entertained with a dinner.

#### Ninth District

(COUNCILOR: J. PAUL McAFEE, M. D., PORTSMOUTH)

#### SCIOTO

"Relation of Scioto County Physicians to Mt. Logan Sanitarium" was the subject discussed by Dr. D. E. Wetterauer at the Nov. 8 meeting of the Hempstead Academy of Medicine in Portsmouth.

#### Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

#### FRANKLIN

"The Treatment of Diseases of the Thyroid Gland," was the subject of an address by Dr. George W. Crile, Jr., Cleveland, at the Nov. 1 meeting of the Columbus Academy of Medicine. At the Nov. 15 meeting, Dr. James B. Campbell of Columbus spoke on "Convulsions."

### Woman's Auxiliary . . .

By MRS. OSCAR W. JEPSEN, CANAL WINCHESTER  
Chairman, Publicity Committee

#### ALLEN

At the regular October meeting of the Woman's Auxiliary to the Allen County Academy of Medicine five new members were admitted. Mrs. M. E. Scheetz reported plans for the

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benefit party to be given in November. Mrs. Karl Ritter gave a review of the "Brookings Institute." Sixty-five tables were filled for play at the annual benefit party given by the members of this group on November 9 in the Memorial Hospital Nurses' Home. The proceeds from the event will be used for the loan scholarship fund for student nurses. The fund is available for a training course at either St. Rita's or Memorial Hospitals.

#### ASHTABULA

The Woman's Auxiliary to the Ashtabula County Medical Society sponsored a benefit tea September 29 at the Nurses' Home. The proceeds were used to establish a nurses' scholarship fund. An attraction of the afternoon was the appearance of a New York creator of millinery. The hats were modeled by members. The October meeting of this auxiliary was held at the home of Mrs. C. C. Campbell, the president. Committee chairmen for the year were announced. Guest speaker for the meeting was Mrs. Eldon Cronquist who spoke on flower arrangement.

#### BUTLER

Two hundred and twenty-five women responded to the invitation of the Woman's Auxiliary to the Butler County Medical Society for a luncheon and style show in the Anthony Wayne Hotel. The crowd was attracted, not only from the social angle but also from the humanitarian appeal of the affair which is to benefit the patients at the Butler County Tuberculosis Hospital. After the luncheon, presided over by Mrs. Azel Ames, a demonstration in fashion models was presented. The committee in charge included Mrs. George Flenner, Mrs. J. A. Mackie and Mrs. Ralph Leyrer, of Hamilton, and Mrs. Fred Brosius and Mrs. E. M. Morris, Middletown.

#### COLUMBIANA

Mrs. J. W. Schoolnic of East Liverpool was elected president of the Columbiana County Medical Society Auxiliary at the meeting in the Wick Hotel in Lisbon. Other officers include Mrs. M. C. Hanysh of Lisbon, vice-president; Mrs. Roy C. Costello, secretary; Mrs. J. S. Jones, treasurer; and Mrs. E. B. Egli of Lisbon, president-elect. Program chairman, Mrs. Guy Byers of Salem, introduced Mrs. T. W. Purviance who spoke on "Personalities in the White House." Mrs. Chester DeWalt of Columbiana, reviewed

the year's activities which included tuberculosis and cancer fund donations, and an initial donation of one hundred dollars to both Salem and East Liverpool Hospitals' nursing fund for the aid of students.

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## CUYAHOGA

The Woman's Auxiliary to the Academy of Medicine of Cleveland and Cuyahoga County met for its fall meeting and tea in November at the home of Mrs. S. C. Lind, president. Guest speaker for the afternoon was Josephine Robertson of the Plain Dealer Staff, presenting, "Highlights on Medical Reporting." As one of its projects, this auxiliary has presented a \$25 prize to an outstanding member of the junior class in each of eleven local schools of nursing.

## ERIE

A business meeting followed the Woman's Auxiliary to the Erie County Medical Society luncheon at the Business Women's Club. Mrs. Paul N. Squire was quest speaker. She gave the history of the little theater in Sandusky. This auxiliary sponsors a radio program over WLEC each Tuesday morning at 10:30.

## ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine held its regular October meeting beginning with dinner at Allyn's. Covers were laid for nineteen members, and one guest Mrs. E. H. Harris, Columbus. Mrs. Charles N. Hoyt, program chairman discussed plans for the year. It was decided that instead of the usual Christmas gift exchange, members would each donate one dollar to be used for a worthwhile project.

## COMING MEETINGS

Ohio State Medical Association Annual Meeting, Columbus, April 19-22, 1949.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9

American Academy of General Practice Annual Scientific Assembly, Cincinnati, March 7-9, 1949.

American College of Physicians, Annual Session, New York City, March 28-April 1, 1949.

Eleventh Post-Collegiate Assembly, O. S. U. College of Medicine, Columbus, Dec. 11.

Medical Study Course, Ohio State University College of Medicine, Columbus, Dec. 6-11.

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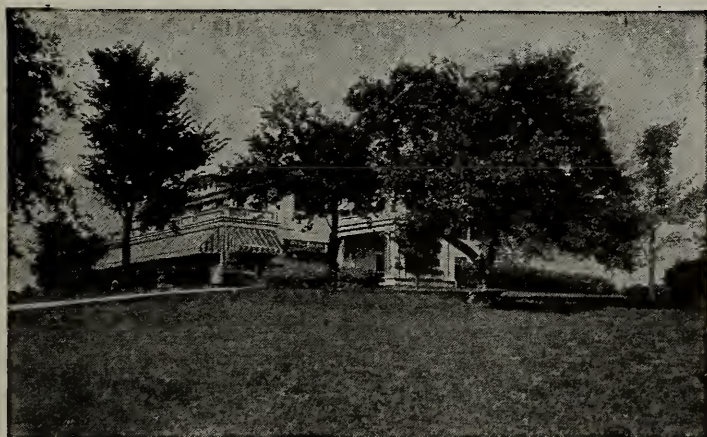
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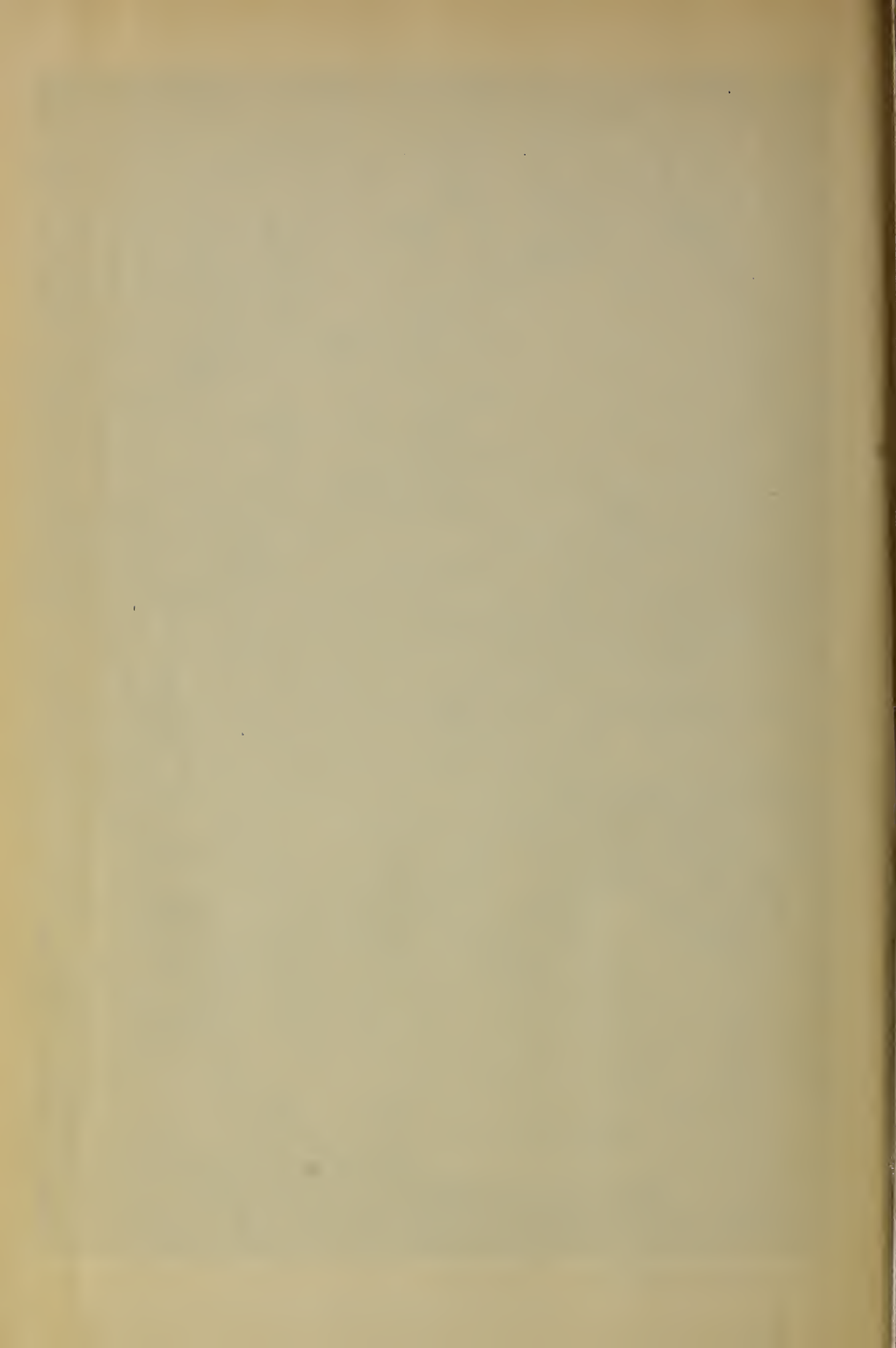
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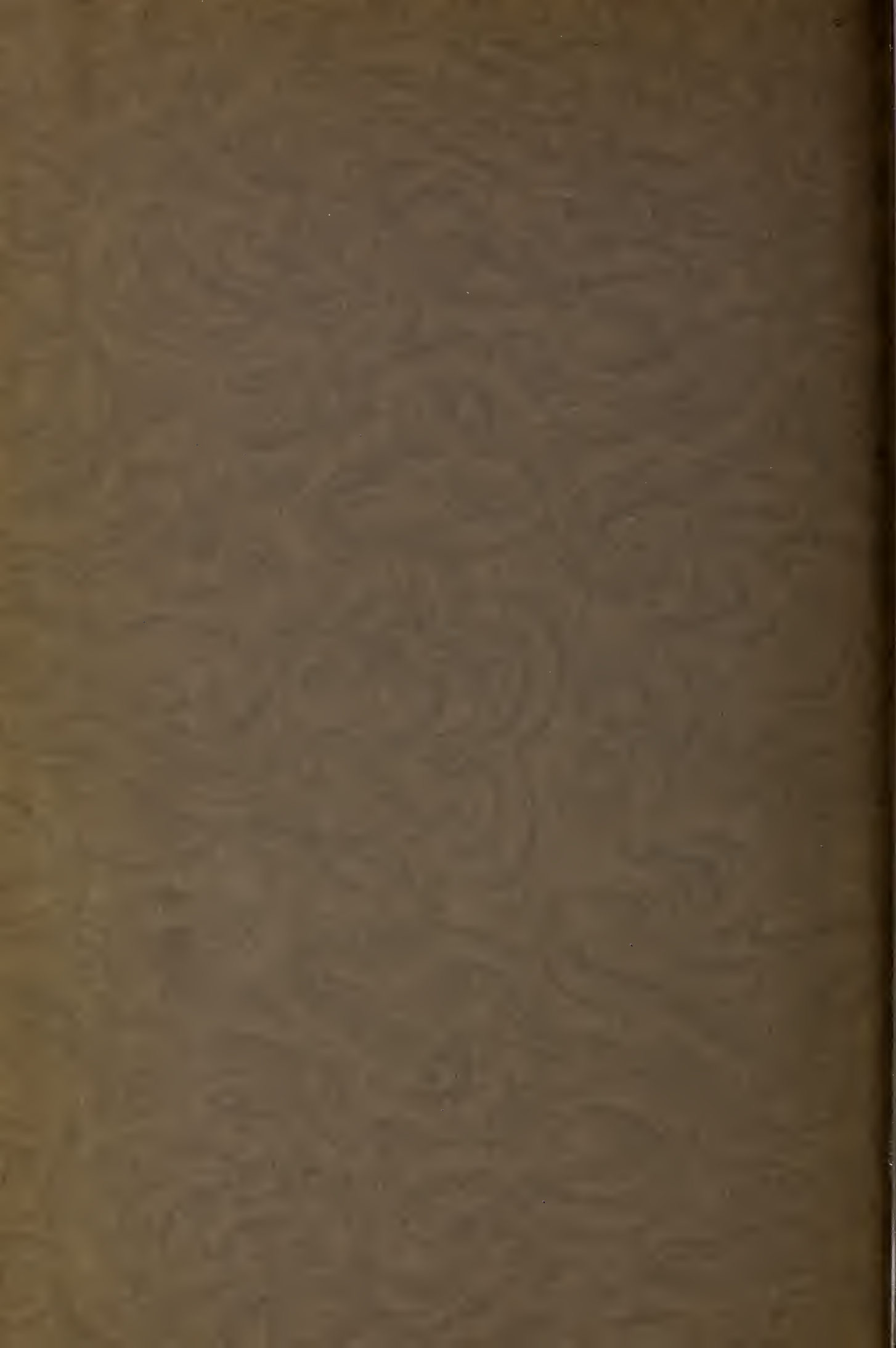


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